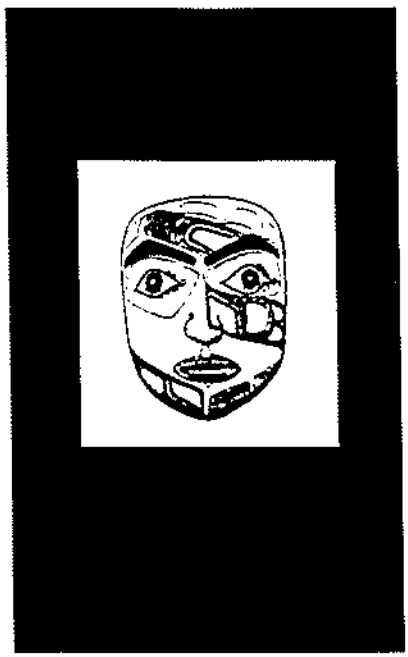

THE MENTAL HEALTH NEEDS OF AMERICAN INDIANS IN WASHINGTON STATE

IMPLICATIONS OF PHASE III MENTAL HEALTH REFORM FOR AMERICAN INDIAN MENTAL HEALTH PROGRAMS

The Mental Health Needs of American Indians in Washington State:

Implications of Phase III Mental Health Reform for American Indian Mental Health Programs.

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Primary Authors: Mike Steenhout and Joe St. Charles.

For additional copies of this document contact:

Mental Health Division,
Department of Social and Health Services
PO Box 45320
Olympia, WA 98504-5320
(800) 446-0259

Acknowledgment of Key Participants

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Phillip L. Ambrose III
John Borders
Bob Brisbois
Sharri Dempsey
Joe Dunn
Ed Fox
Dan Gleason
Judy Gosney
Rex Harrison
Dr. Connie Hunt
Issak Jack
Carol Knobel-Ames
Dennis Olsen
Josephine E. Marcelley
Huss Malik
Yvonne Misiaszek
Dale M. Nachreiner
Thom O'Rourke
Amy Lyn Ribera
Marilyn Scott
Dennis Sexton
John Stevens
Robert Tanna
Pete Blair
Preston Boyd
Georgia Britt
Tam Dixon
Brenda Dorsey
Ralph Forquera
Steve Goblin
Gwendolyn R. Gua
Kathrine Horne
Deborah Juarez
Tim Justice
Toni Lodge
Peter Maburger
John Makey
Laurie Mattson
Liz Mueller
June O'Brien
Mike Peters
Bob Russell
Maria Sector
M. Helen Spencer
Joseph Stone
Diane I. Vendiola

Quick List of Abbreviations

(AIDC) American Indian Data Committee
(AIHC) American Indian Health Commission for Washington State
(CDMHP) County Designated Mental Health Care Professional
(CMS) Centers for Medicare and Medicaid
(CMHC) Community Mental Health Centers Act
(DASA) Division of Alcohol and Substance Abuse
(DOH) Department of Health
(DSHS) Department of Social and Health Services
(FFS) Prevailing Medicaid Fee-For-Service
(FMAP) Federal Medical Assistance Percentage
(FQHC) Federally Qualified Health Center
(GOIA) Governor's Office of Indian Affairs
(HCFA) Health Care Finance Administration
(IHS) Indian Health Service
(IPAC) Indian Policy Advisory Council
(IPSS) Indian Policy Support Services
(ITA) Involuntary Treatment Act
(JCAHO) Joint Commission of Accreditation of Healthcare Organizations
(MAA) Medical Assistance Administration
(MHD) Mental Health Division
(MOA) Memorandum of Agreement Between IHS and HCFA
(OMB) Office of Management and Budget
(PAR) Participatory Action Research
(PHP) Pre-Paid Health Plan
(RCW) Revised Code of Washington
(RSN) Regional Support Network
(SIHB) Seattle Indian Health Board
(SPIPA) South Puget Intertribal Planning Agency

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Forward

This is the second edition of this document. The first edition was published in 1997. It has been re-written at the request of the Indian Policy Advisory Committee (IPAC). The purpose and objectives of IPAC are to guide the implementation of the Governor's Accord and Administrative Policy 7.01, seeking unity among the tribal governments, Indian organizations, and the divisions within the Department of Social and Health Services (DSHS). IPAC's role is to assist the collective needs of the Tribal governments an d other American Indian organizations to assure quality and comprehensive service delivery to all American Indians and Alaska Natives in Washington State.

This revised document will add to the discussion of mental health service needs of American Indians in Washington State and the barriers that prevent these needs from being met. The primary areas on which this update focuses are: 1) the impacts that the Memorandum of Agreement (MOA) signed December 19, 1996, between Indian Health Services (IHS) and Health Care Finance Administration (HCFA)[1] have had on tribal-based mental health care programs; 2) licensing, certification, and accreditation status of tribal-based mental health programs and their clinical staff; 3) the level of access that tribal-based programs currently have to inpatient beds for their clients and how access can be improved; 4) jurisdictional issues surrounding the involuntary commitment of American Indians living on reservations and trust land; 5) the efforts that Regional Support Networks (RSNs) have made to provide culturally competent mental health services to Medicaid eligible American Indians and to include tribal governments in their policy development process; 6) the lack of data that accurately describes the mental health status of American Indians served by tribal-based programs, how this impacts these programs, and the need for statewide efforts to maintain such data.

[1] Now the Centers for Medicare and Medicaid Services (CMS).

Preface

On May 12, 1990, numerous mental health professionals representing Washington State tribes, Indian organizations, and state agencies testified before the Committee on Interior and Insular Affairs, of the U.S. House of Representatives, concerning the mental health service needs of American Indians and Alaska Natives in the State of Washington, and the many barriers that prevented these needs from being met.[2,3] Their testimony clearly communicated the financial, cultural, systemic, and geographic barriers that American Indian people face in accessing culturally competent mental health services. Since then, a number of documents that further address the mental health service needs of American Indians in Washington State, and the barriers that prevent those needs from being met, have been produced.[4]

In 1991, the Swinomish Tribal Mental Health Project published *A Gathering of Wisdoms*, a text that detailed how an American Indian mental health program operates, and that offered an extensive discussion of mental health needs and barrier issues for American Indians in Washington State.[5] The text was developed through collaborative research and writing processes which evolved from a series of intertribal mental health conferences throughout Washington State. This unique and informative text is considered by many to be the best handbook of American Indian mental health issues written to date.

Also in 1991, a short but powerful position paper was written by Dr. Dolores Gregory (former director of the Behavioral Health Division, Portland Area Indian Health Services) that discussed the creation of Washington State's Regional Support Network (RSN) system, and how this system has failed to deliver culturally competent mental health services to American Indian populations. In addition, Dr. Gregory presented data showing that American Indian school aged adolescents, compared to other ethnic groups, are much more likely to be seriously emotionally disturbed, and yet receive the least amount of overall services.

Since its establishment in 1994, the American Indian Health Commission for Washington State (AIHC), a committee of tribal delegates, urban Indian health organizations, and individual American Indians has produced position papers concerning American Indian mental health needs and barrier issues. AIHC, in conjunction with the Indian Policy Advisory Committee (IPAC), initiated the

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[2] For the remainder of this document, the term American Indian is meant to include Alaska Native people.

[3] On April 1st, 2000, the U.S. Census Bureau estimated that there were 158,940 American Indian and Alaska Native people in Washington State. It is believed that, similar to national trends, roughly 56 percent of American Indian people in Washington State are living in urban areas (Grossman, et al., 1994; Shukovsky, 1994; U.S. Census Bureau, 2000; Forquera, 2001).

[4] It is important to note that Washington State has a very diverse American Indian population and although there are many cultural similarities between the different tribes, each of the communities possesses a unique culture, complete with values, traditions, and a history of their own (Ladue, 1980; Swinomish, 1991).

[5] This document is currently being updated and the newer version should be available soon.

writing of the *South Puget Intertribal Planning Agency (SPIPA) Mental Health Project* (1996), a document that attempted to further document American Indian mental health needs and barrier issues.[6] The *SPIPA Project* further investigated the problems of the RSN system that Dr. Gregory presented in her paper, as well as the implications that Washington State's phase III mental health reform efforts have for American Indians in the State of Washington.[7] Like *A Gathering of Wisdoms*, the *SPIPA Project* was developed utilizing collaborative research processes.

In 1997, the first version of this document, titled T*he Mental Health Needs of American Indians in Washington State: Implications of Phase III Mental Health Reform for American Indian Mental Health Programs*, was published by Mike Steenhout and Joe St. Charles. This document was updated by Mike Steenhout and will add to the discussion of mental health service needs of American Indians in Washington State and the barriers that prevent these needs from being met. It will touch on similar subject material as these other documents, while exploring some of the newest issues at hand. These issues are addressed in the context of the most current policy changes proposed and initiated by the Centers for Medicare and Medicaid Services (CMS), IHS, and the State of Washington.

[6] For the remainder of this document, the *SPIPA Mental Health Project* will be referred to as the *SPIPA Project*.

[7] On December 10, 1996, MHD submitted a federal waiver renewal request (pursuant to 1915B of the Social Security Act) which authorized the integration of the State of Washington's inpatient and outpatient mental health services under a "seamless" managed care model system, commonly referred to as phase III of mental health reform. "The integrated inpatient and outpatient system of care shall be responsible to provide a seamless system of outpatient and inpatient medically necessary mental health services (on a voluntary and involuntary basis) to publicly funded persons in a way that meets individual needs" (MHD, 1996:2).

Introduction

The primary purpose of this document is to provide useful information for tribal- and urban-based American Indian mental health care programs. This document investigates the unique mental health needs of American Indians in Washington State, and the cultural, systemic, and geographic barriers that prevent these needs from being met. In most cases, tribal- and urban-based American Indian mental health programs have limited access to the financial and technical resources needed to adequately address these issues through research and negotiation.

This document is meant for two distinct audiences. The first audience is composed of administrators and providers of tribal- and urban-based American Indian mental health programs and the Indian Health Service (IHS). The second audience is composed of the Centers for Medicare and Medicaid Services (CMS), various divisions of the Department of Social and Health Services (DSHS), including Mental Health Division (MHD), Medical Assistance Administration (MAA), Division of Alcohol and Substance Abuse (DASA), and Indian Policy and Support Services (IPSS), as well as the Governor's Office of Indian Affairs (GOIA), and the ten RSNs in Washington State that have American Indian tribes in their regions.

The primary research questions addressed in this study are: 1) what are the mental health service needs of American Indians in Washington State? 2) What barriers prevent these needs from being met? 3) How can our publicly funded mental health care system more effectively meet these service needs? These questions are explored in the context of MHD's ongoing mental health reform efforts and the implementation of the Memorandum of Agreement (MOA) between Indian Health Services and the Health Care Finance Administration (HCFA) (see Appendix One) that enables tribal-based programs to bill Medicaid outside of the RSN System for services provided to Medicaid eligible American Indians on a fee-for-service basis. This document provides a snapshot of these complex issues and lays a framework for future inquiry.

Most American Indians in Washington State receive outpatient mental health services at American Indian mental health care programs. American Indian people choose to receive services at these programs because they offer culturally competent care and are more accessible than mainstream programs.[8] Washington State's mental health system has generally failed to provide culturally competent and accessible mental health services to American Indian people (Gregory, 1991; Steenhout, 1996; Steenhout & St. Charles, 1997).

The MOA has created significant new opportunities for tribal-based mental health programs to increase revenue for their programs. Although many difficulties arose

[8] "Mainstream programs" means mental health care programs that are dominant in non-Indian society (non-holistic programs) which RSNs generally contract.

during the initial implementation of the MOA (primarily concerning the potential for dual-payment, and certification and licensing of tribal-based programs), these issues seem to have been resolved. These resolutions are evident by recent conversations with CMS, IHS, MHD, and MAA, in which professionals representing these agencies now recognize the following: 1) monies available to tribes under the MOA are not the same monies dedicated to the State of Washington under the waiver process[9]; 2) the RSN System still must provide the same services to American Indians it was responsible for providing prior to the MOA, including access to inpatient beds; and, 3) that MHD cannot require tribal-based mental health care programs to become licensed by the State of Washington prior to billing under the MOA.

This document has nine chapters. Chapter One discusses ethical and methodological issues that arise when people research and write about American Indian issues. In this chapter we also describe the research methodology used in this document. In addition, we discuss why in most cases, typical Western scientific research approaches fail in Indian Country and how Participatory Action Research (PAR) can be utilized as an effective research approach in this cross-cultural setting.

Chapter Two explores the connection between the history of Indian-non-Indian relations and the current state of American Indian mental health. We discuss how the clash of cultures between American Indians and Western society has resulted in the subjugation, impoverishment and cultural degradation of American Indian communities and how these factors significantly contribute to the current prevalence of mental illnesses among American Indians.

Chapter Three outlines the history of federal Indian policy and the unique legal relationship American Indian tribes have with the U.S. government. In doing so, we provide a brief overview of the history of federal Indian policy and explain the current legal status of American Indian tribes.

Chapter Four details what is presently known about the state of mental health of American Indians in Washington State. Currently, there is not a reliable set, or source, of data describing the mental health status of American Indians in Washington State. We also explore important issues surrounding the use of statistics as a means to describe the mental health status of American Indians, and the need for tribes to retain control of data which describe the state of mental health within their communities.

Chapter Five explores the current state of relations between tribes, and state and local governments in Washington State (mainly in the context of agencies that deal

[9] Every two years the State of Washington is required to submit a waiver to CMS describing the State's mental health care system and make certain commitments prior to receiving federal block grant funding to operate the system.

with mental health issues). In doing so, we explore the history of these relations. We also provide a model for improved relations between these governments.

Chapter Six analyzes the two parallel publicly funded mental health systems that American Indians in Washington State can access for mental health care services (the IHS and State systems). We also discuss the necessity of cultural competency in the delivery of mental health services to American Indian people, and explain the differences between these two systems with regard to such cultural competency. In addition, we discuss the funding mechanisms that support Washington State's mental health system as a whole and the need for American Indian mental health programs to have reasonable access to portions of this funding, as well as issues surrounding the delivery of crisis response and ITA services to tribal communities by the RSNs.

In Chapter Seven, we discuss the fiscal impacts that the MOA has had on American Indian Tribes. In addition, we discuss the debate that arose between MHD, MAA, and tribes over licensing and certification issues detailed in the MOA. Finally, we will discuss how the MOA has not solved another key barrier issue, access to the inpatient system. In fact, while tribal-based programs can be reimbursed for outpatient services provided to clients under the MOA, these same clients do not have equal and fair access to the inpatient system compared to clients in the mainstream system.

In Chapter Eight we present the conclusions of our study. In Chapter Nine we offer recommendations for policy change and future inquiry.

Executive Summary

In this document we explored the mental health service needs of American Indians in Washington State and the barriers that prevent those needs from being met. We addressed these issues in the context of policy change taking place at the federal, state, and local government levels that impact tribal- and urban-based mental health care programs, discussing the potential effect of these policy changes on American Indian people.

The primary purpose of this document is to provide useful information for tribal- and urban-based American Indian mental health programs. This document investigates the unique mental health needs of American Indians in Washington State, and the cultural, systemic, and geographic barriers that prevent these needs from being met. In most cases, tribal- and urban-based American Indian mental health programs have limited access to the financial and technical resources needed to adequately address these issues.

This document is meant for two distinct audiences. The first audience is composed of administrators and providers of tribal- and urban-based American Indian mental health programs. The second audience is composed of the Indian Health Service (IHS), Centers for Medicare and Medicaid (CMS), various divisions of the Department of Social and Health Services (DSHS), including MHD, Medical Assistance Administration (MAA), Division of Alcohol and Substance Abuse (DASA), and Indian Policy and Support Services (IPSS), as well as the Governor's Office of Indian Affairs (GOIA), and the ten Regional Support Networks (RSNs) in Washington State that have American Indian tribes in their regions.

Our participatory research process involved tribal members and employees (mental health providers and administrators) from numerous Washington State tribes and Indian organizations. It also involved employees of Mental Health Division (MHD), IPSS, GOIA, MAA, DASA, RSNs, IHS, the Seattle Indian Health Board (SIHB), and the N.A.T.I.V.E. Project. All participants had a significant impact on the research process. A fifteen member reading committee composed of various tribal, federal and state government professionals who participated in the research process, reviewed the rough draft. The final draft of this document is the accumulation of the knowledge and experiences of all participants, combined with the project's findings.

The primary research questions addressed in this study are: 1) what are the mental health service needs of American Indians in Washington State? 2) What barriers prevent these needs from being met? 3) How can our publicly funded mental health care system more effectively meet these service needs? These research questions are explored in the context of mental health reform efforts at the national and state levels. This document provides a snapshot of complex issues and lays a framework

for future inquiry. The following is a summary of our main findings and recommendations:

General Findings

- Of the twenty-nine federally recognized tribes in the State of Washington, twenty-two have mental health care programs currently operating (one of which is operated by IHS directly). Twenty of these tribes have obtained provider numbers for their mental health programs to bill under the MOA. Of these twenty tribes, only twelve seem to be actively billing. Between January and September of 2001, these programs have billed for approximately $2.5 million in Medicaid reimbursement.

- There are at least four tribes and several Indian organizations that are currently providing some type of billable mental health care services that have not obtained a provider number and are not currently billing. Overall, nine of the ten tribes not currently billing wish to do so in the near future.

- Tribes use a wide-range of staffing strategies for their mental health programs. The most common scenario is to staff mental health programs with part-time or full-time mid-level professionals and contract for psychiatric services (primarily for the prescribing of psychotropic medication). Tribes also utilize a wide-variety of other professionals in their programs, such as psychologists, traditional healers, nurse practioners, and counselors. Of the nineteen tribes with mental health programs that were interviewed, seventeen require that their staff be certified or licensed by the State of Washington.

- From recent interviews with twenty-five tribes and nine RSNs, it seems that significant improvements have been made by RSNs to understand and respect that tribes are sovereign nations existing within their boundaries, and are unique and fundamentally different than other minority groups. Additionally, more RSNs are contracting with tribes to support their programs, require that their contractors make efforts to provide culturally competent services to American Indians, have more formal agreements with tribes in place relating to ITA jurisdiction issues, and allow more participation on their governing boards by tribes. Much of this improvement can be attributed to an increase in 7.01 planning and policy development within the RSNs.

- Of the nine RSNs interviewed, two felt they had excellent relations with the tribes in their jurisdiction, six felt they had good relationships, and one felt the relationship was neutral (neither good nor bad).[10] When the same

[10] Interviewees were given the choices of excellent, good, neutral, poor, and terrible.

question was posed to tribes, one viewed their relationship with the RSN as excellent, while ten felt the relationships were good, seven describe the relations as neutral, and seven depicted the relationship as poor. No RSN or tribe rated the current relationship as terrible.

- American Indians in Washington State have unique mental health needs that, in most cases, can only be met by traditional support systems within their communities. This includes having access to culturally competent mental health providers who can assess the needs of a client and then guide that client to effective services, whether traditional, Western, or a combination of both.

- Similar to national trends, American Indians in Washington State suffer from considerably high rates of mental health problems such as depression, substance abuse, and destructive "acting-out" type behavior (such as suicide, fighting, and acting recklessly).

- Tribal-based mental health programs estimate that an average of 70-90 percent of their clients suffer from co-occurring disorders (i.e. dual-diagnosis of mental health illness and drug and alcohol addiction). Providers at these programs feel these high levels of dual-diagnosis can be largely attributed to clients self-medicating.

- Other common mental illnesses in American Indian populations in Washington State are major depression and dysthymic disorder (major depression and dysthymia often occur together in the same individual in a so-called "double depression"), posttraumatic stress disorder, personality disorders, serious anxiety, panic disorders, and serious emotional problems.

- American Indian children in Washington State seem to suffer from shockingly high rates of Serious Emotional Disturbance (SED), suicide and substance abuse.

- The mental health issues currently faced by American Indians, as well as the difficulties tribal communities confront in addressing those issues, are substantially a product of the history of Indian-non-Indian relationships in this country. The value systems, beliefs and motivations that European Americans have had over time have given rise to numerous governmental policies and practices that, along with the disruptions caused by European introduced diseases, have resulted in a history marked by the subjugation, impoverishment, and cultural degradation of American Indian communities.

- The history of American Indian subjugation, impoverishment and cultural degradation has greatly contributed to the high levels of depression,

alcoholism and destructive acting-out behavior among American Indians today. Furthermore, this history has undermined the ability of many American Indian communities to fully respond to mental health (and mental health related) problems.

- Most American Indians in Washington State primarily receive mental health services at tribal- and urban-based American Indian mental health programs. American Indians choose to receive services at these programs because they offer culturally competent care and the facilities are more accessible than mainstream programs.

- Delivering culturally competent mental health services to American Indian populations is a complicated endeavor; this is especially true for mainstream mental health programs that find it almost impossible to deliver such services. In order for a provider to deliver effective mental health services to American Indian populations, the provider must be specially trained or experienced in providing services to American Indian people. Furthermore, the provider should be familiar with the tribal community from which the client hails and willing to deliver services within that community.

- There is almost a consensus among tribes that the RSN system still does not meet the legal mandate of providing culturally competent services to American Indians. Twenty-four of the twenty-five tribes interviewed felt that the RSN System was not meeting this mandate.

- With few exceptions, tribal-based mental health programs have little or no access to beds in the publicly funded inpatient mental health care system.

- Many people assume that IHS provides an extensive array of mental health services to American Indians. This assumption is incorrect. IHS has dedicated less than 2 percent of their fiscal year 2001 annual budget for mental health services.

- Many people assume that IHS is the only governmental agency which has the responsibility to provide mental health services to American Indian populations; this assumption is incorrect. As state residents, American Indians have the right to access Washington State's mental health system on an equal basis to other residents.

- Under the MOA, tribal-based mental health programs can bill for Medicaid services provided to clients on a fee for service basis (as currently available under the Office of Management and Budget [OMB], Federally Qualified Health Center [FQHC], or prevailing Medicaid fee-for-service [FFS] rates). All tribes in the State of Washington that are now billing under the MOA for

mental health services are doing so at the OMB Rate of $185.00 an encounter.[11]

- To bill under the MOA, tribal-based mental health programs must meet all conditions and requirements applicable under the Medicaid statue, and standards necessary to meet state licensure criteria, but need not obtain a state license. Under the MOA, IHS, not the State of Washington, has the responsibility to negotiate with tribes to ensure these standards are met. The State of Washington has no jurisdictional or other legal rights under the MOA to place any requirements, or make any demands, of tribes prior to them obtaining a Medicaid provider number from MAA to bill.

- At least ten tribes feel that they have the capacity and are interested in the option of issuing court orders requiring tribal members to undergo mental health care treatment. Of course, to be effective, these orders would have to be recognized by county and state governments, who control access to these treatment facilities. At least one tribe in the State has successfully negotiated an agreement of this type with their local county government.

- Very few tribal-based mental health programs are maintaining datasets on their clientele for program planning and grant writing purposes. However, almost all of the tribes interviewed stated that they would be very interested in participating in a statewide effort to standardize and maintain datasets about the prevalence of mental health problems among American Indian populations. This data would have to be compiled and controlled by a tribal organization, such as the Northwest Portland Area Indian Health Board (NPAIHB), rather than a state or federal agency.

- Almost every tribe in the State of Washington provides some level of support to their tribal members in the application process for Medicaid. With few exceptions, DSHS outreach workers that provide this type of support have been ineffective.

- Estimates of the needs of tribes for publicly funded inpatient services varied by quantity and type of services. Most tribes estimated their need for inpatient placement between one and five cases annually. Four tribes estimated a much higher unmet need, at ten, fifteen, sixteen, and twenty-four cases per year respectively. An annual statewide estimate for the need of tribal-based mental health care programs would be roughly 130-150 cases. These cases are split evenly (50/50) between youth and adults. Additionally, at least 70 percent of these cases would be dual diagnosed clients. Lastly, about 60 percent of these cases would be short-term, crisis stabilization cases.

[11] Commonly referred to as the IHS Rate.

Recommendations

- Tribal-based mental health programs would benefit greatly from a statewide conference between tribes, the SIHB and N.A.T.I.V.E. Project, and staff representing CMS, IHS, MHD, IPSS, and DASA. Some of the key issues this conference should focus on include: 1) billing under the MOA; 2) improving access for tribes to the State of Washington's mental health and ADATSA inpatient systems and how these systems could better serve tribes in the future; 3) the need for improved data describing the prevalence of mental health illnesses and dual-diagnosis in the clientele served by American Indian programs; 4) and, how MHD and DASA could combine resources to better serve American Indians suffering from dual-diagnosis.

- Tribes need to better familiarize themselves with the Community Mental Health Services Act, Chapter 71.24 of the Revised Code of Washington (RCW), and Chapter 388-865 of the Washington Administrative Code (see Appendices two and three). These laws detail most aspects of how the public mental health care system operates in the State of Washington.

- RSNs should require the County Designated Mental Health Professional (CDMHP) to maintain written agreements with tribes that address jurisdiction issues relating to involuntary treatment procedures on reservations and trust lands.

- Following what seems to be the beginning of a national trend, the State of Washington should create a seamless system of care to better serve those dually-diagnosed with mental illness and drug and alcohol addiction. This system should address the disorders that these clients suffer from simultaneously, rather than sequentially. This system would require closer collaboration between MHD and DASA, or even possibly an integration of some programs and facilities. Several tribal-based programs in the State of Washington currently operate a seamless system of care within their chemical dependency and mental health programs.

- With many tribal-based mental health programs increasing their revenues by billing under the MOA, national accreditation is becoming a more viable option for these programs. CARF and AAAHP offer three-year accreditation for between $3,700 and $5,000 per three-year period. Both of these organizations stated that they have had great success in accrediting American Indian behavioral health programs in the past.

- IPAC should address the need for a statewide effort to standardize and maintain datasets about the prevalence of mental health problems among American Indian populations. This data, which would need to be compiled

and controlled by a tribal organization, is greatly needed for grant writing, program planning, and lobbying.

- IPAC should request funding from IHS to conduct a cost-benefit analysis of building an IHS Hospital in the Pacific Northwest. This hospital should include a psychiatric ward.

- IPAC should address how tribal-based mental health programs can improve access to the State of Washington's inpatient mental health care system. Although it may not be realistic in today's political environment, possible options, all of which would require revising of the Community Mental Health Care Services Act (RCW 71.24), include: 1) allow tribes to form single or multiple RSNs among themselves, or with neighboring county governments; 2) require RSNs to coordinate directly with tribes on inpatient placements, removing their contracted providers from the process altogether; 3) require MHD to coordinate directly with tribes on inpatient placements, removing RSNs from the process altogether; 4) redirect a portion of inpatient funding to create mental health bed space in the four existing Alcohol and Drug Addiction Treatment and Support Act (ADATSA) facilities in the State of Washington that specialize in the treatment of American Indians (this could be the easiest way to improve services to the dually-diagnosed). A more realistic option, which would not require revising RCW 71.24, would be to approach CMS with the plan to fund "Evaluation and Treatment", and "Community Hospital Beds" for tribes that are funded with 100 percent federal dollars.

- IPAC should initiate a workgroup comprised of representation from tribal- and urban-based American Indian mental health programs, MHD, and CMS, to discuss the current inpatient needs of tribes in the State of Washington. Today, tribes have little or no access to the publicly funded inpatient system.

Chapter One: Research Methodology

This chapter has three sections. In the first section we discuss ethical and practical issues pertaining to people researching and writing about American Indian issues. In the second section we explain the research model used to research and write this document. In the last section we explain Participatory Action Research (PAR), and its effectiveness as both a research methodology and as a process for facilitating good communication and relations in a cross-cultural setting.

Researching and Writing About American Indian Issues

Researching and writing about American Indian issues demands a specialized set of professional ethics, considerations, and responsibilities (American Indian Law Center, 1994; Fixico, 1996; Mihesuah, 1993; Northern Arizona University, 1993; Wilson, 1996). Some of the more important considerations researchers should embrace if they wish to produce an insightful and valid representation of American Indian issues are:

- Permission to conduct the research in a tribal community must be obtained from the tribal council (Freeman, 1994; Mihesuah, 1993; Northern Arizona, 1993; Norton & Mason, 1996).
- The point of view of the tribe should be clearly presented in any discussion of issues pertaining to the tribe (Fixico, 1996; Northern Arizona University, 1993).
- Tribal members should be directly involved in every step of the research process, from planning the methodology and pre-testing the instrument, to the collection of data and the analysis and interpretation (review) of all findings (Mihesuah, 1993; Northern Arizona University, 1993).
- Research instruments must be adapted to be used in the cross-cultural environments of tribal communities (LaFromboise & Plake, 1984).
- The findings of the study must be communicated clearly to the tribe (LaFromboise & Plake, 1984; Ryan & Spence, 1978).
- The study must produce a product (data and documents) that is of actual use to the tribe. The tribe should agree that the research effort is needed, and possess at least partial ownership of the final product.
- Researchers must have, and demonstrate, a high degree of respect for American Indians by visiting and interacting with people in their communities (Fixico, 1996).
- Researchers must recognize the social and cultural pluralism of different societies. Recognizing that one's own cultural values affect choice making and interpretations in research will help to prevent irresponsible decision making (Northern Arizona University, 1993).

These many points and considerations are especially relevant when social scientists research and write about American Indian mental health issues. Mental health

issues are very personal to tribal communities, and tribes are wary of sharing information about these issues with outsiders (Swinomish, 1991). A researcher will not gain a valid representation of the mental health needs of an American Indian community without being a member or an employee of the tribe itself, having substantial experience with the community and knowledge of the community's day-to-day affairs, or being in full collaboration with the tribe throughout the needs assessment. Put simply, if the tribe is not involved in every step of the research process, the findings will have little or no validity.

Numerous researchers have provided insight into why typical Western scientific research approaches fail to produce valid findings and insightful recommendations to improve mental health in American Indian communities (Brislin, 1979, 1981; Colorado, 1988; Edwards & Edwards 1980; Rogler, 1989; Ryan, 1980; Ryan & Spence, 1978; Trimble, 1977). LaFromboise and Plake (1984) list some of those reasons as:

- The minimal involvement of tribal people in the research effort.
- The obtrusive role of investigators.
- Controversies over the content of research.
- The shortcomings of conventional research training frequently result in the insensitivity of many researchers to important cultural, environmental and social influences on the behavior of people from ethnic cultural groups.
- Conventional research serves purposes of control and manipulation, and may have inherent problems of application to American Indian concerns due to the issue of self-determination.

By far, the majority of research done on American Indian mental health issues has been conducted by non-Indian people (LaFromboise & Plake, 1984; Ryan, 1980; Ryan & Spence, 1978). In many cases, social scientists who study mental health issues are unfamiliar with the American Indian tribes about which they are writing (Red Horse, 1980; Ryan & Spence, 1978). "Naiveté unfolds as a cultural ignorance which prevails in most professional circles. A crucial barrier results: professionals fail to understand the preeminent and ubiquitous concern that tribal peoples have regarding rights to heritage, tribal customs, and extended family" (Red Horse, 1980:1). Respecting these concerns is integral to the success of a research project. "In doing research with Indian people ... the real clue to obtaining information is being aware of the values, the traditions, the customs, and the way of life of the people you are studying" (Ryan & Spence, 1978:15).

Ryan and Spence (1978) note that an extensive amount of mental health research on American Indians has been conducted, and yet that research has generally failed to produce useful information for American Indian mental health programs. These authors cite communication breakdowns, ineffective research instruments, and research findings not being communicated back to the tribal mental health programs, as being the main causes of failure. In addition, the authors infer that

tribes have come to realize that in most cases, actual change or action rarely comes as a direct result of a study's findings, and have tended to lose interest in participating in future studies because they view participation as a waste of time.

Conducting research projects that study tribal communities, but create products that are useless to tribes, should be eliminated. Irrelevant research in the cross-cultural setting can be destructive because institutional racism permeates most academic institutions, is present in most mainstream research methodologies, and can affect the decision making of research practitioners. A form of cultural imperialism is represented by research projects that study tribal communities but offer findings that will likely be irrelevant to the tribe; this is especially true if the tribe itself is not asked to participate in the research process.

"Historically, the relationship between researchers and tribes has resulted in numerous conflicts; tribes have encountered many abuses and often perceive no benefit from participating in research" (Norton & Mason, 1996:856). A major barrier to the researcher who is attempting to conduct research with an American Indian tribe is the residual feelings of distrust the community members harbor toward past researchers who have used the findings of a study against the tribe. As a direct result of these past actions, " ... a high level of distrust exists among Native American people to anyone asking questions, regardless of the good promised by the results of the research ... this suspicion and lack of trust on the part of tribal leaders may be detrimental to research interests but are not necessarily damaging to tribal interests" (Ryan, 1980:508).

When tribes participate in research efforts that do not benefit their communities, they eventually lose interest in research and begin to view participation as a waste of time; as a direct result, future researchers with the very best intentions in their research goals cannot access the community. Norton and Mason (1996) note that tribal governments have " ... become increasingly aggressive in evaluating research projects to determine whether the questions are of interest or will provide any benefits to the tribe" (Norton & Mason, 1996:58). Retaining control over the process and findings of a research effort that pertains to a tribal community is fundamental to a tribe's right of self-determination and their status as a sovereign nation.

Upon completion of a research project, the results should be presented to the tribal council. The results should be presented " ... in a form that is interpretable and meaningful and that may be used by service providers and administrators for the purpose of grant writing or lobbying for program funding" (Norton & Mason, 1996:859). If a physical product (such as a document or data) is produced in a research project, copies should be made available to all of the tribes who participated in the process.

Research Methodology

The research process used to update this document involved tribal members and employees (mental health providers and administrators) from twenty-five of the federally recognized tribes in Washington State, as well as representatives of Indian organizations. It also involved employees of CMS, IHS, MHD, IPSS, MAA, DASA, and RSNs. All participants had a significant impact on the research process. The rough draft was reviewed by a 15 member reading committee composed of various professionals who participated in the research process. Additionally, anyone who participated in the research process and requested to review the draft was given the opportunity to do so. The final draft of this document is the accumulation of the knowledge and experience of all participants, combined with the project's findings.

Realizing the shortcomings of a typical Western scientific research approach in the tribal setting, we utilized a PAR research model. PAR is an inclusive process that promotes action for social change. PAR encourages full collaboration between the researcher and the subject community from start to finish, and can utilize verbal approaches in data collection as opposed to written approaches. PAR "... has the explicit intention of collectively investigating the world to transform it by linking the creation of knowledge about social reality with concrete social action ... it is a democratic approach for generating information and learning tools useful to community-based individuals, groups, and movements as a tool for working towards bottom-up social change" (Williams, 1996:i). Though the PAR approach is much more time-consuming than mainstream methods, it is consistent with American Indian values of group and community processes (Barndt, 1981; Colorado, 1988; McKenzie, et al., 1995; Sanchez & Almeida, 1992).

In total, we conducted more than 90 telephone and personal interviews, and participated in several meetings between state, tribal, and Indian organization officials. Overall, people were generally willing to speak and share information with us, resulting in the accumulation of an excellent amount of primary data. The project gained momentum and changed form with every interview, survey, and meeting. In many of the interviews that were conducted, participants were concerned that they not be quoted; as a result, the primary data in this paper is presented in aggregate form.

Participatory Action Research for Research, Communication, and Policy Development

Aside from its utility as a research methodology, PAR is an excellent method to cultivate good relations between American Indian tribes, and state and county agencies. This is because its processes can be used in the establishment of good communication and a working relationship in a cross-cultural setting. Thus, PAR is a powerful social science method for both communication and research in which the

researcher or the agency recognizes the tribe's role as co-researchers, rather than subjects, clients, or data sources. In the PAR process, the stakeholders have:

- Equal influence in defining the initial parameters of the method or model of the communication or research.
- Equal participation and control during the process.
- Equal opportunity to interpret and define findings.
- Equal ownership of the information resulting from the communication or research effort.

PAR depends upon the community participating actively throughout the process, from the initial design of the study to the analysis of the results, and in ensuing action (Whyte, et al., 1989). PAR is an inclusive, qualitative process that utilizes both typical Western scientific and other innovative data gathering methods modeled to meet the specific needs of the community involved (Williams, 1996). "PAR thus contrasts sharply with the conventional model of pure research, in which members of organizations and communities are treated as passive subjects, with some of them participating only to the extent of authorizing the project, being its subjects, and receiving the results" (Whyte, et al., 1989:514). PAR understands and acknowledges that:

- Knowledge of a problem and the expertise to solve it exists within the community.
- The researchers and the community need to reach some explicit agreements about the shared expectations in the process, and then join together to study and resolve the problem; a sharing of strengths will result in a stronger and more meaningful end product.
- Communities that are participants rather than subjects are more involved and will invest more time to ensure that all relevant data is shared.
- The researcher and the community will be challenged by events, ideas, information and arguments posed by one another throughout the process. In essence, the PAR process builds momentum, as every step of the process can be seen as potentially contributing to, being informed by, and/or influencing the next step.

PAR requires building a trusting relationship between the researcher and the American Indian tribe during the cross-cultural effort. In some instances, PAR takes more time and effort than typical Western scientific research approaches would require. The cultural differences and troubled history between American Indian tribes and Western society complicate the situation further. American Indian communities have fundamentally different values, world views, traditions, communication processes, and religious beliefs than do most non-Indians (Putman, 1982; Swinomish, 1991).

Despite the extra time and effort sometimes required, PAR appears to be an ideal process to guide future interaction between State government and Washington's diverse American Indian population. If the process is conducted correctly, it can bridge two distinctly different cultures since PAR is consistent with American Indian values of group and community processes, yet is a Western scientific approach (Barndt, 1981; Colorado, 1988; McKenzie, et al., 1995; Sanchez & Almeida, 1992). The adaptability of PAR provides a useful opportunity for state officials and American Indian communities to interact in ways that produce useful results and respect mutual cultural differences. "Because PAR leads researchers into previously unfamiliar pathways, involvement in the process is likely to stimulate us to think in new ways about old and new theoretical problems, thus generating provocative new ideas" (Whyte, 1991:42.). Figure one illustrates an example of a PAR process:

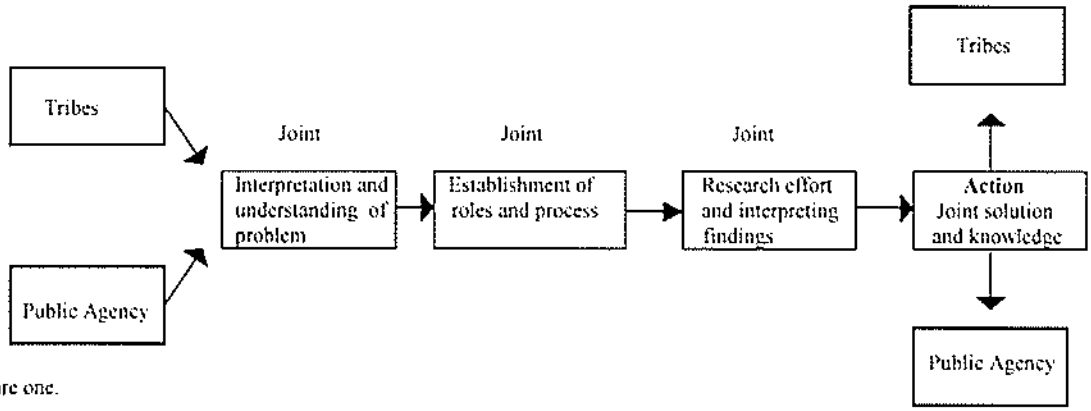

Figure one.

PAR is a form of applied research that concentrates on creating change and solutions rather than new theory. Figure two compares PAR and typical Western scientific research cycles.

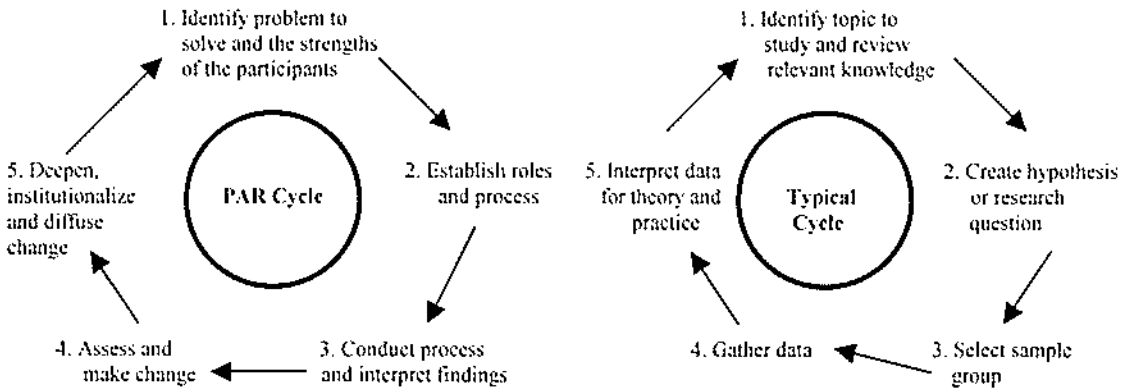

Figure two (Portions adopted from Walton & Gaffney (1991)).

PAR can be a powerful process for the development of effective public policy. In some regards, MHD has embraced the meaning and importance of PAR processes in the development of phase III policies and in the assistance provided to some tribes to enable billing under the MOA. Although no longer in use, MHD officials worked collaboratively with tribes in the creation and development of a licensing mechanism that could be used by tribal councils to certify their mental health programs. In taking this collaborative position, MHD acknowledges, respects, and works within the parameters of the established government-to-government relationship between tribes in Washington State and the State of Washington. Additionally, by allowing the inclusion of tribal officials from the beginning of the process in addressing the licensing issue, MHD has respected, to a degree, the importance of tribal involvement in the development of policy that impacts their communities.

MHD's efforts to directly involve tribes and American Indian organizations in policy formulation is a positive development for state-tribal relations. However, although outside professionals have been invited to participate in MHD's policy development, the balance of power still favors MHD; this is largely due to the responsibility which the State of Washington has to manage Medicaid funds. Therefore, it is important to note that the PAR process MHD has initiated, is limited in its ability to be fully collaborative.

Chapter Two: The Relation of American Indian Mental Health to the History of Indian-Non-Indian Relations

In order to understand the mental health issues currently faced by American Indians in Washington State, as well as the difficulties tribal communities confront in addressing those issues, one must first understand the historical context of Indian-non-Indian relations. This historical knowledge is important because both the nature and prevalence of American Indian mental health problems, as well as the difficulties contemporary tribal communities confront in fully responding to those problems, are substantially a product of this history (Berlin, 1987; LaDue, 1981; LaFromboise & Bigfoot, 1988; Lake, 1982; Swinomish, 1991). The pervasiveness of mental illnesses among American Indians today (expressed in high rates of depression, alcoholism, and destructive "acting-out" behavior) is, in large part, the result of a history marked by the subjugation, impoverishment, and cultural degradation of American Indian communities. Furthermore, the difficulties many tribal communities face in dealing with these mental health problems are similarly a product of this history. Many of the methods and networks traditionally employed by American Indian communities to deal with their mental health needs have been disrupted, and to a certain degree even destroyed, as a result of the perennial attack on traditional American Indian ways of life.

In this chapter we discuss the connection between the history of Indian-non-Indian relationships and the current state of American Indian mental health. To facilitate analysis, this chapter is divided into three sections. In the first section we address the causal relationship American Indian subjugation, impoverishment, and cultural degradation has with contemporary American Indian mental illness. In the second section we discuss some pertinent facets of the early clash of cultures between American Indian tribes and Western society. In the third section we summarize the governmental policies and practices that have proved the most detrimental to American Indian mental health.

Influences on American Indian Mental Health

One must be wary of generalizations about the state of American Indian mental health today. Researchers have noted that types of mental illness, levels of severity, and rates of occurrence vary significantly from one tribe to another (Berlin, 1987; Dizmang, et al., 1987; Holmren, et al., 1983; Levy, 1992; Mail & Johnson, 1993; May, 1987; Miller, 1979; Shore, 1974). These rates also vary significantly between tribal- and urban-based American Indians (Beauvais, 1992). However, American Indian communities do have similarities in regard to the mental health issues they face, and these issues are notably different from those of other racial groups (Bach & Bornstein, 1981; Beauvais, 1992; Guilmet & Whited,

1989; Mail & Johnson, 1993; May & Dizmang, 1974; Swinomish, 1991). Researchers and mental health professionals have noted the pervasiveness of depression, alcohol abuse, and destructive acting-out behavior (such as suicide, rape, fighting, and domestic violence) among American Indians (Beauvais, 1992; Bechtold, 1988; LaDue, 1981; Lake, 1982; Mail & Johnson, 1993; Manson, 1989; May, 1987; McShane, 1988; Miller, 1979; Swinomish, 1991). Numerous researchers have also supported the hypothesis that these mental health problems are symptomatic of the cultural degradation, subjugation, and severe life stresses (such as racism, poverty, and child abuse) that American Indians confront today (Beane, et al., 1980; Beauvais, 1992; Berlin, 1987; Dinges & Duong-Tran, 1993; Gregory, 1991; Johnson, 1994; LaDue, 1981; Manson, et al., 1989; May, 1987; McShane, 1988; Swinomish, 1991; Tower, 1989). In this section we address the relation of these symptoms to their underlying causes, causes that are, primarily, a product of the history of Indian-non-Indian relations.

Cultural Degradation, Subjugation, and Severe Life Stresses

Though significant improvements have been made in recent decades, historically United States federal-Indian policies have had the byproduct, and at times even the overt intent, of degrading and disrupting traditional American Indian cultures. Due to such policies and the devastating effects the introduction of European diseases had on North America's Indian populations, tribal communities have suffered cultural disruptions such as the loss of traditional knowledge, languages, and ways of life. These cultural disruptions have had a profoundly negative effect on American Indian mental health, an effect which is aggravated by the continuing failure of much of mainstream America to view American Indians and their cultures as anything other than inferior (Fixico, 1986; Mander, 1991). Swinomish (1991) speaks of the cultural confusion and lowered self-esteem caused by this cultural degradation, as well as its relation to American Indian mental health:

> Indian people experiencing any of the problems in this triad [depression, alcohol abuse, and destructive "acting-out" behavior] often seem to have problems related to cultural identity. The history of attack on Indian identity and culture, along with the severe life stresses affecting Indian communities today results in widespread cultural confusion. A negative cultural identity not only contributes to mental health problems, it is a mental health problem. An Indian person is unable to maintain psychological well-being without a sense of the cultural vitality and meaningfulness of Indian ways. For instance, the low self esteem often found in Indian teenagers is often tied to confusions about cultural identity and can contribute to self-defeating or dangerous behavior (such as drinking, fighting, or suicide). Lack of a strong and positive cultural identity can put Indian people at risk for any of a variety of mental health problems. Cultural insecurity (caused by past oppression and present life stresses) creates the psychological condition in which the triad of depression, alcoholism and destructive acting-out manifests itself (Swinomish, 1991:46).

Not only has cultural degradation contributed to the high rates of depression, alcohol abuse, and destructive acting-out behavior among American Indians, it has also eroded the social cohesion of many American Indian communities, exacerbating the problem of destructive acting-out behavior by reducing social constraints (Berlin, 1987; Tower, 1989). Yakima (1995) states that, "[t]he collective trauma that the YIN [Yakama Indian Nation] has continued to experience over time are injuries inflicted on the community life and the cultural bonds that connect people ... The deadly effects of collective trauma on the YIN have been to kill the spirit of kinship and destroy the inhibitions that govern the individual from the inside" (Yakima, 1995:2).

Another factor contributing to the mental health problems that American Indians face today is the history of American Indian subjugation by the United States government. In regard to the persecution of American Indians and their loss of control over their own communities, Beane, et al. (1980) state that this can result in "survivor syndrome."

> The trauma of persecution is vastly different from the usual trauma attributable to accident or nature. The victim is unable to conceive of its coming to an end at some fixed point in time. It consists of conscious, dehumanizing, often sadistic behavior on the part of one group toward another. And it is these dimensions of persecution that lead to the inclusion of additional symptoms to the survivor syndrome: guilt and self-loathing, an inability to cope with anger, chronic depression, impoverished object relationships, and long-term personality changes (persecution, distress, apathy). These are the repetitive themes among all survivors ...
>
> Survivors feel an incredible rage, but have an inability to express the rage at the intended object. Anger at one's subjugation and humiliation cannot be directed against the oppressor because of real and fantasized concerns about retribution. The anger becomes internalized (the source of depressive symptomatology) and acted out against self or within one's group (family, tribal members, etc.). Its clinical manifestations among American Indians include high alcoholism rates, suicides, homicides, family disintegration, and an assortment of social and educational failures (Beane, et al., 1980:15).

Severe life stresses also contribute to the mental health problems confronted by many American Indians today (Beauvais, 1992; LaFromboise & Bigfoot, 1988; May, 1987; McShane, 1988; Swinomish, 1991; Tower, 1989). Swinomish (1991) states:

> Severe life stresses place Indian people at a high risk for mental health problems. On a national level, Indian communities are affected by very high levels of poverty (reported at between 30-90 percent), unemployment (13-40 percent), accidental death (three times the national rate), alcoholism (30-80 percent), domestic violence, teen pregnancies, child neglect and suicide (2 times the

> national rate). At the Swinomish Tribe, 10 of every 13 students drop out of high school. Nationally, Indian people have the lowest educational level of any minority group. Only 15 percent of Indian adults have graduated from high school or have a GED. These tragic circumstances pose an obvious threat to individual and family stability (Swinomish, 1991:44).

Like the subjugation and cultural degradation faced by American Indian communities today, these severe life stresses are largely the product of the history of Indian-non-Indian relations. For instance, the poverty and unemployment experienced today by American Indian communities is primarily the result of U.S. governmental policies. An example is that because of these policies, many tribes were forcibly relocated to reservations where they were compelled to forsake traditional methods of subsistence and become farmers (Cingolani, 1973; Deloria, 1977; Pevar, 1992). However, not only were these areas frequently unfit for farming, but the government often failed to sufficiently provide tribal communities with the knowledge and tools necessary for this socio-economic conversion (Cingolani, 1973; Grossman, 1979; Porter, 1990). Furthermore, the economic support that many tribes were guaranteed as a condition for ceding huge tracts of land to the U.S. and settling on these reservations, was often fraudulently mismanaged by government officials (Dale, 1969; Fritz, 1963; Prucha, 1985).

Similarly, the other severe life stresses listed above (such as alcoholism, child neglect, and suicide) are also a product of the history of Indian-non-Indian relations. Furthermore, though these life stresses help to cause the triad of depression, alcohol abuse and destructive acting-out behavior, they are also symptomatic of that triad (Swinomish, 1991). For instance, in a study of American Indians incarcerated for homicide, Bachman (1991) quotes an inmate as saying: "I remember watching my parents getting drunk on weekends - things would usually end up in a fight. My brothers and sisters and I just sat on the bunk bed and watched. Like I said, when you see, when you hear, you start to act like the person you're not supposed to be" (Bachman, 1991:486). In this way the history of Indian-non-Indian relationships has proved particularly damaging. With this history as the initial catalyst, these symptoms and causes reinforce each other in a continuous cycle of mental illness within a community (Swinomish, 1991).

<u>The Disruption of Traditional Networks of Healing</u>

Not only is the history of Indian-non-Indian relations the most significant factor in the nature and prevalence of contemporary American Indian mental health problems, many contemporary tribal communities also confront difficulties in fully responding to those problems as a result of this history. The same cultural degradation that is such a significant causal factor in American Indian mental illness, has robbed American Indian communities of many of the methods and networks traditionally employed to deal with their mental health needs. In this regard, the history of American Indian religious persecution has proven particularly

damaging. American Indian communities have long possessed traditional methods for treating physical, psychological and spiritual problems, but religious persecution resulted in much of this traditional knowledge being destroyed. Religious persecution resulted in this loss because American Indian people have traditionally viewed spiritual well being as interconnected with physical, psychological, and social well being (Swinomish, 1991). Since tribal experts skilled in the treatment of physical and psychological problems were also usually spiritual healers, attacks on Indian religion destroyed many traditional healing systems (Swinomish, 1991).

Steenhout & St. Charles (1997) interviewed seventeen tribal-based mental health programs in the State of Washington, finding that only ten programs integrate traditional healing or other cultural activities directly into their service delivery models. The most common reason the other seven programs were not using these approaches in their service delivery models was that the "traditional healing" knowledge was not readily available or completely lost in their communities. Several of these seven programs also mentioned that they were working on ways to build this capacity in to their programs, even if it meant asking for the assistance of other local tribes.

The loss of life associated with European-introduced diseases and U.S. wars of colonialism also had radically negative effects on the traditional American Indian healing systems. These influences have reduced North America's Indian population by ninety percent from its pre-Columbian level (Zinn, 1980). Since much of an American Indian culture's traditional healing knowledge was often held by a limited number of experts and because this knowledge was passed on orally, the loss of a majority of a culture's population in a relatively short period of time resulted in much of traditional healing knowledge being lost forever (Boyd, 1985; Guilmet, et al, 1991; Smith, 1994; Storm, et al., 1991).

The Clash of Cultures

When *Cristoforo Columbo* first landed in the New World he called its inhabitants *Indios*, due to his erroneous belief that he had succeeded in reaching the "Indies," as the Far East was then called. These *Indios* greeted Columbus and his men with gifts and treated them with honor, as was the custom of the Arawaks of the Bahama Islands. Columbus wrote to the King and Queen of Spain: "So tractable, so peaceable, are these people that I swear to your Majesties there is not in the world a better nation. They love their neighbors as themselves, and their discourse is ever sweet and gentle, and accompanied with a smile; and though it is true that they are naked, yet their manners are decorous and praiseworthy" (Brown, 1970:2). However, Columbus saw these customs as signs of heathenism and weakness. He wrote that they should be "... made to work, sow and do all that is necessary and to adopt our ways" (Brown, 1970:2). In this section we explore the detrimental effect both beliefs such as this and European diseases have had on American Indian

communities and their cultures, and subsequently on American Indian mental health.

Introduced Diseases

European hubris was not all Columbus and those who would follow him brought to the Americas. Tuberculosis, pneumonia, dysentery, bubonic plague and smallpox are all diseases that were introduced to this continent by Europeans. American Indian populations were devastated by these diseases because they had negligible natural resistance to them. Chase (1987) writes:

> No one knows just how many Indians died from these diseases, but the best estimates are that they killed between 50 and 90 percent of the Indians in America. The first plague epidemic swept New England in 1619 and 1620, taking more than 90 percent of the Indians with it. The first smallpox epidemic probably occurred in the same area around 1617, and was followed every twenty-five years with successors that eliminated several Indian tribes along the East Coast. On Nantucket, for instance, four epidemics between 1659 and 1792 killed all but twenty out of 3,000 in one tribe (Chase, 1987:104).[12]

American Indians of the Pacific Northwest were probably first introduced to European diseases in the early 1780s, when smallpox was contracted from the crews of European trading vessels (Dale, 1969; Deloria, 1977; Guilmet, et al., 1991; Swinomish, 1991). Writing of the epidemic this precipitated, Dale (1969) states that "... even in the interior, where it was carried by Indians who had been trading on the coast, it destroyed from one-third to one-half of some of the [American Indian] bands" (Dale, 1969:11). As had occurred on the East Coast, this first epidemic was followed by a succession of others. "Influenza struck in 1829-1832 and wiped out nine-tenths of the native inhabitants of the Willamette Valley; smallpox came ... [to the Pacific Northwest] again in 1835 and 1846; measles in 1847; and smallpox once again in 1852-1853. There is no way to determine how many Indians were killed in one of these outbreaks, but it is clear that some bands were wiped out, others decimated, and all weakened by the disease" (Dale, 1969:11).

The devastation produced by these epidemics "...disrupted social, economic, and ceremonial networks and left much of the Indian population stunned with loss" (Swinomish, 1991:18). The extent and longevity of these disruptions, as well as their effect on contemporary American Indian mental health, can not be underestimated. In fact, LaDue, et al. (1981) argue that the mental health

[12] Similarly, Zinn (1980) notes: "The Indian population of 10 million that lived north of Mexico when Columbus came would ultimately be reduced to less than a million ... A Dutch traveler in New Netherland wrote in 1656 that 'the Indians ... affirm, that before the arrival of the Christians, and before the smallpox broke out amongst them, they were ten times as numerous as they now are, and that their population had been melted down by this disease ...'" (Zinn, 1980:16).

problems facing Northwest coastal tribes today are primarily the product of the lasting social and cultural breakdowns that resulted from these early epidemics.

Epidemics caused these breakdowns, in part, by forcing cultures to devolve "... to a point where much cumulated cultural tradition is lost, institutions break down, and social structures become simpler. These changes are adaptive in that they allow the culture to survive changed circumstances" (Boyd, 1985:526). Furthermore, in oral cultures,

> [u]nder epidemic conditions specialized knowledge and skills are lost due to the death of specialists before replacements can be trained or ordained. Everyday practices such as raising food and child raising are more likely to be preserved because they are likely to be widespread, but knowledge that requires special training or secret knowledge is likely to be lost to some communities ... Such specialized knowledge often includes health care and spiritual techniques (Smith, 1994:60).

Finally, the inability of shamans and other traditional healers to control these epidemics certainly shook the faith of American Indians in their traditional metaphysical systems (Guilmet, et al., 1991; Storm, et al., 1991).

However, not only did these epidemics have a detrimental effect on American Indian mental health through the social and cultural breakdowns they caused directly, they were also damaging because they expedited the U.S. government's efforts to conquer, relocate, and assimilate tribal communities. With populations devastated by disease, the ability of American Indian communities to resist U.S. colonialism was seriously undermined (Prucha, 1985). The failure to effectively combat colonialism has resulted in American Indian subjugation and impoverishment, as well as the degradation of traditional tribal cultures.

<u>European Values, Beliefs, and Motivations</u>

Efforts to conquer, relocate, and assimilate American Indian communities were engendered by the value systems, beliefs and motivations that European Americans have had over time. Racial and cultural chauvinism, the belief in an edict from God calling for the subjugation of nature, and, after the American Revolution, the ideological belief in the inevitable expansion of the United States' "empire of liberty," are all pronounced aspects of the history of popular thought in this country. These beliefs, along with land hunger, greed, and the misguided efforts of Christians and humanitarians, have produced colonial and federal policies that have been profoundly detrimental to American Indian communities and their cultures. In the remainder of this section, we discuss these beliefs and motivations, as well as their negative effects on contemporary American Indian mental health.

According to White (1967), Christianity's Western form contains the doctrine that "... God planned all of this [creation] explicitly for man's benefit and rule: no item in the physical creation had any purpose save to serve man's purposes," and that it was "God's will that man exploit nature for his proper ends" (White, 1967:1205). Among colonial Puritans, this doctrine and their belief that America was the new promised land (the land preordained for them as God's chosen people), combined to form a powerful argument for displacing American Indian communities. When the Pilgrims arrived in New England and found the territory already inhabited by tribes of American Indians, the governor of the Massachusetts Bay colony, John Winthrop, created an excuse to take tribal land by declaring the area legally a "vacuum." The Indians, he said, had not "subdued" the land, and therefore had no right to it (Segal & Stineback, 1977; Zinn, 1980). Winthrop wrote:

> That which is common to all is proper to none. This savage people ruleth over many lands without title or property; for they enclose no ground, neither have they cattle to maintain it, but remove their dwellings as they have occasion, or as they can prevail against their neighbors. And why may not Christians have liberty to go and dwell amongst them in their wastelands and woods (leaving them such places as they have manured for their corn) as lawfully as Abraham did among the Sodomites (Segal & Stineback, 1977:50)?

This belief in a divine mandate to subdue the earth and the view that American Indians failed to meet the requirements of this mandate because they were not agrarians, supported many of the efforts of the New England colonies and the United States to extirpate tribes from their land through displacement, relocation or, during the mid-1800's, genocide.[13] These efforts continued even though Puritan control over New England politics had ended by 1692. Segal and Stineback (1977) argue that:

> What even twentieth-century Americans have clearly inherited from New England Puritans... is a need to see themselves as divinely appointed users of the earth for the good of all mankind... Nineteenth-century politicians seldom referred to Genesis 1:28 when they argued that Indians had to forfeit their territory because they did not do anything with it besides hunting, gathering, and fishing; but the essence of their claim was no different from John Winthrop's to the 'vacant' lands of New England (Segal & Stineback, 1977:220).

[13] It should be noted that though "[t]he colonials liked to regard the Indians as members of a nomadic hunting race with no fixed habitation, roaming over thousands of acres of virgin wilderness ... [t]his wish-fulfilling dream of the nomadic Indian (which Presidents John Adams and Theodore Roosevelt, among others, later used as an excuse for taking Indian land) ignored the fact that many of the tribes of eastern North America lived in populous towns and villages. Such towns contained houses, streets, fortifications, centers for civic and religious events, as well as corn fields, orchards, and garden plots" (Jacobs, 1985:111). However, as will be explained below, the efforts toward American Indian displacement, relocation, and genocide, were based on more than just the failure of American Indian communities to be agrarian. As recently as the 1960's, what were often demanded of American Indian people was not just that they become farmers, but that they completely assimilated into mainstream American society (Fixico, 1986; Fritz, 1963; Pevar, 1992; Zinn, 1980).

There were other influences besides the Puritan paradigm that generated the post-1692 belief that European Americans were divinely appointed users of the earth, who had every right to displace tribes from their lands. Until relatively recently, it has been difficult for European Americans to view American Indian cultures as anything other than inherently inferior to their own (Cadwalader & Deloria, 1984; Deloria, 1977; Deloria et al., 1984; Jacobs, 1985; Mander, 1991; Swinomish, 1991). Mander (1991) states that:

> Disregard for Indian well-being was and is made possible by one fundamental rationalization: that our society represents the ultimate expression of evolution, its final flowering. It is this attitude - and its corresponding belief that native societies represent an earlier, lower form on the evolutionary ladder, upon which we occupy the highest rung - that seems to unify all modern political perspectives... (Mander, 1991:68).

Another influence (arising after the American Revolution) was the belief in the necessity of expanding the United States' territory in order to maintain America's "empire of liberty," as Thomas Jefferson called it (White, 1991). Jeffersonians believed that in order to maintain an independent and democratically virtuous society, the United States needed to be a nation based on commercial agriculture. This agricultural-based nation, in turn, depended on land for a rapidly growing population. "Without land, the United States would face a Malthusian crisis and sink back into European conditions of overpopulation, inequality, decadence, and dependence" (White, 1991:63). This was the rationale behind Jefferson's Louisiana Purchase in 1803.

However, it was not until the mid-1840's and the concept of "manifest destiny," that this Jeffersonian belief turned into a truly aggressive and popular national policy of expansion. The product of a New York newspaperman named John O'Sullivan, the theory of manifest destiny stated that "Providence" had given the United States the right to occupy the continent. Embracing the Jeffersonian belief in a divine mission, this theory gained popular support by combining the views of the Jeffersonians with the more pragmatic argument that expansion would provide a cure for both the political and economic troubles the United States was then facing (White, 1991; Zinn, 1980).

As this argument for expansion expresses, land hunger, greed and the pressures of a burgeoning population also helped to engender policies of displacement and extermination. Many American Indian communities were pushed from their territories (even territories acknowledged earlier as theirs in treaties with the United States government) because of the insatiable desire of European Americans for lands suitable for farming or rich in natural resources (Brown 1970; Embry 1956; Zinn, 1980). Writing of the federal policy of forcibly relocating eastern tribal communities to the West, a policy in effect for most of the 1800's, Zinn (1980) states:

> The forces that led to removal ... came from industrialization and commerce, the growth of populations, of railroads and cities, the rise in value of land, and the greed of businessmen. "Party managers and land speculators manipulated the growing excitement ... Press and pulpit whipped up the frenzy." Out of that frenzy the Indians were to end up dead or exiled, the land speculators richer, the politicians more powerful. As for the poor white frontiersman, he played the part of a pawn, pushed into the first violent encounters, but soon dispensable (Zinn, 1980:135).

Finally, racism contributed to these antagonistic policies. Though early European colonists ethnocentrically perceived American Indians as hostile and treacherous savages, many others respected them and treated them fairly.[14] However, as American history progressed, the racism of European Americans in regard to American Indians increased in both prevalence and degree. Due to military conflicts between imperial powers (in which tribes often took part), and later between the United States and tribes, European Americans increasingly dehumanized the American Indians they saw as enemies (Jacobs, 1985). This racism was reinforced by scientific theories, widely accepted in Europe and the U.S. during the nineteenth century, that held that non-Caucasian peoples were biologically inferior (Gould, 1981; Shattuck & Norgren, 1991; White, 1991).

Examples of this mixture of racism, land hunger, greed, and the belief in a divine mission are numerous. For instance, the official attitude during the colonial period can be seen in advice given by General Jeffrey Amherst to one of his subordinates: "You will do well to try to inoculate the Indians by means of blankets in which smallpox patients have slept, as well as by other means that can serve to extirpate this execrable race" (Embry, 1956:17). The attitude of the United States government after independence was not much different. In 1830 Lewis Case (who served as U.S. Secretary of War, minister to France, and governor of the Michigan territory), in making the case for American Indian removal in the face of U.S. expansion, wrote that one must not regret "... the progress of civilization and improvement, the triumph of industry and art, by which these regions have been reclaimed, and over which freedom, religion, and science are extending their sway" (Zinn, 1980:131). He lamented that this "progress" could not be achieved with "... a smaller sacrifice; that the aboriginal population had accommodated themselves to the inevitable change of their condition ... but such a wish is vain. A barbarous people, depending for subsistence upon the scanty and precarious supplies furnished by the chase, cannot live in contact with a civilized community" (Zinn, 1980:131). Similarly, in 1851, California Governor Peter H. Burnett stated that "... a war of extermination will continue to be waged between the two races until the Indian race becomes extinct, must be expected; while we cannot anticipate this

[14] The Quakers, for instance, were known for their respectful dealings with American Indians (Jacobs, 1985; Segal & Stineback, 1977).

result but with painful regret, the inevitable destiny of the race is beyond the power and wisdom of man to avert" (Fleras & Elliott, 1992:143).

Regardless of the theological or ideological underpinnings of these efforts to displace American Indians from their lands, the results were uniformly detrimental to tribal communities and their traditional ways of life (and subsequently to American Indian mental health). American Indian communities were disrupted through the destruction and loss of life associated with the military conflicts often precipitated by these relocation efforts. Many tribes (such as the Navaho, Cherokee, Ponca, and Nez Perce) also suffered a severe loss of life as a result of the disease, starvation, and other hardships associated with their forced relocation (Brown, 1970; Dale, 1969; Zinn, 1980). Furthermore, not only were American Indian communities impoverished by the loss of land, they were culturally disrupted as well. Segal & Stineback (1977) write that:

> Nothing was, or is to this day, as important to Native Americans as the land itself. In a way that few colonial Europeans could understand, the land *was* Indian culture: it provided Native Americans with their sense of a fixed place in the order of the world, with their religious observances, and with their lasting faith in the importance of the struggling but united community as opposed to the ambitious, acquisitive individual that seemed to them to characterize Europeans in the New World [italics in original] (Segal & Stineback, 1977:27).

In the end however, the most culturally destructive federal-Indian policies in American history (and subsequently the most damaging to American Indian mental health) were not primarily meant to displace American Indians from their land, but to assimilate them into mainstream society. Ironically, these policies were initially the product of well-intentioned Christians and humanitarians (Deloria, et al., 1984; Fritz, 1963; Prucha 1985). Believing that all human beings were created innately equal by God, and yet perceiving American Indians as culturally inferior, these Christians and humanitarians hoped to raise American Indians to the level of their white counterparts (Prucha, 1985). These European Americans felt that:

> The Indians' culture could and should be transformed to equal or approximate that of their white neighbors. The inexorable progress exhibited in the history of human societies meant that the Indian would move through stages of society, from savagery to barbarism to ultimate civilization, just as the ancestors of the Europeans themselves had passed through those stages centuries ago. But Christian benevolence could not wait for the evolutionary progress to work itself out over centuries. It was the duty of Christians to speed up the process and to reform the Indian societies through positive and sometimes forcible means, the chief of which were instruction in agriculture and education in Christian schools (Prucha, 1985:10).

By the late 1800s, detrimental federal policy, the continuing encroachment of whites on to tribal land, and the scandalously corrupt management of reservations by government officials, groups of Christians and humanitarians became convinced that the assimilation of American Indians into Anglo-American culture was desirable and the only practical and humane answer (Dale, 1969; Deloria, et al., 1984; Grossman, 1979; Fritz, 1963; Shattuck & Norgren, 1991). From 1887 to 1934, influenced both by Christians and humanitarians and European Americans eager to obtain tribal lands, the federal government systematically dismantled most American Indian reservations and redistributed a significant portion of the land to white settlers. It was hoped that dismantling reservations would disrupt communal tribal cultures and force American Indians to adopt the individualistic ways of the American farmer (Bordewich, 1996; Cadwalader & Deloria, 1984; Dale, 1969; Fritz, 1963; Pevar, 1992). Simultaneously, thousands of American Indian children were forcibly removed from their homes and placed in boarding schools, with the overt intention of stripping them of their traditional cultures and inculcating them in the ways of the European American (Swinomish, 1991; Utter, 1993).

Though American Indians were given a respite from this drive toward assimilation beginning in 1934, it was resumed again a decade later. From 1945 until 1960, the federal government renewed its policy of assimilation by attempting to eliminate both its unique legal relationship with tribes and its special responsibilities toward them. The federal government also pursued this assimilation policy through programs that encouraged and facilitated the relocation of American Indians from reservations to urban areas. These efforts were motivated by the patriotic post-war belief that all Americans, including American Indians, should conform to a modernized middle-class society and pursue the American dream (Fixico, 1986). More significantly, the federal government was also motivated by the desire to terminate costly services provided to American Indians and make tribal lands available to white Americans (Fixico, 1986; Swinomish, 1991).

As is more thoroughly discussed in the following section, the economically and culturally destructive effects these assimilation policies have had on American Indian communities are monumental. While only partly fulfilling the goal of assimilation, these policies have wreaked havoc on tribal communities and left them with pressing mental health concerns.

Pernicious Governmental Policies and Practices

In this chapter we have argued that a significant causal factor in the pervasiveness of mental illnesses among American Indians today, as well as in the difficulties many tribal communities face in dealing with their mental health issues, is the cultural degradation, subjugation, and severe life stresses currently faced by American Indians. These factors are, in turn, largely a product of the history of Indian-non-Indian relations. In this final section of this chapter, we explore some of

the specific governmental polices and practices which have been engendered by the beliefs, values and motivations discussed above, and which have proven particularly detrimental to American Indian mental health.

American Indian Removal and Relocation

Between 1828 and 1887, the main thrust of federal-Indian policy was the forced relocation of tribes to reservations. In a number of ways, this policy led to the impoverishment of American Indian communities and erosion of their social, cultural, and political systems. For instance, American Indian communities were routinely disrupted through the destruction and loss of life that resulted from the military conflicts this policy often precipitated. For some communities, these disruptions were exacerbated by the severe loss of life (resulting from disease, starvation, and other hardships) brought about by their forced relocations (Brown, 1970; Dale, 1969; Zinn, 1980). However, all tribal communities were disrupted through the erosion of their traditional systems of subsistence.

At the time of Columbus' arrival, North America's Indian communities practiced self-sustaining methods of subsistence. These methods took the form of both hunting and gathering societies, and semi agricultural communities. Though bad seasons and warfare could bring hardship, the mixed hunting-gathering-horticultural system of the American Indians was generally a stable one (Prucha, 1985). "The goal of production was economic security, not maximized use of resources, and security was achieved by diversity of production" (Prucha, 1985:34). However, contact with white settlers changed these American Indian economies, and in many cases, destroyed them (Dale, 1969; Prucha, 1985; White, 1991).

Most American Indian communities relied on mobility in order to harvest different foods seasonally. However, the European colonists, and later the Americans, "... established permanent settlements, bounded the land with fences and private ownership, and transformed the ecosystems on which the Indians had built their subsistence economies" (Prucha, 1985:35). As their traditional means of survival disappeared, American Indians were drawn into the market network of white society and became increasingly dependent upon it. The fur trade expedited this dependence as American Indian efforts to secure white manufactured goods eventually threatened the supply of game. Items such as guns soon turned from luxuries to necessities, indispensable for providing subsistence as hunting grounds were depleted by American Indians and whites alike. Over time, American Indians became impoverished, and their traditional methods of subsistence began to erode (Prucha, 1985).

For many tribes, relocation onto reservations completed their cultural erosion. Land cessions and the depletion of game further undermined the ability of American Indians to provide for themselves, and the annuities that they received in payment for their land replaced their traditional methods of subsistence (Dale,

1969; Prucha, 1985). The loss of traditional ways of life dispirited American Indian communities and disrupted their social, cultural, and political systems (Berlin, 1987; Prucha, 1985; Tower, 1989).

In order to fill the vacuum left by traditional methods of subsistence, the U.S. government encouraged American Indians to become farmers, but they were usually unwilling to replace the old ways with those of the white man (Cingolani, 1973; Deloria, 1977; Pevar, 1992; Prucha, 1985). Furthermore, reservation land was often unfit for farming, and the government failed to adequately provide the knowledge and tools necessary for this socio-economic conversion (Cingolani, 1973; Fritz, 1963; Grossman, 1979; Porter, 1990). Though many American Indians continued as best they could to practice traditional methods of subsistence, and many others adjusted to the demands of the new economic system, most American Indian communities eventually became impoverished and dependent upon government annuities (Dale, 1969; Fritz, 1963; Prucha, 1985; White, 1991).

The General Allotment Act

Passed in 1887, this General Allotment Act (also known as the Dawes Act), was the result of pressure from two groups of European Americans. The first group was comprised of land-speculators, specifically the railroads and gold seekers who were eager to acquire tribal lands (Cingolani, 1973; Grossman, 1979; Fritz, 1963). The second group was made up of well-intentioned Christians and humanitarians who felt that assimilation was the only hope for the survival of America's Indians. The act initially delegated to the Bureau of Indian Affairs (BIA) authority to allot 160 acres of tribal land to each head of household and 40 acres to each minor. The act was quickly amended to provide for allotments of 80 acres of agricultural land, or 160 acres of grazing land, to each tribal member. After all eligible American Indians had received their share, the surplus was purchased by the U.S. government at a nominal sum and resold to white settlers.

The architect of the Allotment Act, Senator Henry L. Dawes (along with the Christians and humanitarians who supported it), hoped that the act would lead to the break down of tribal relationships and the communal nature of American Indian societies, forcing tribal members to adopt the cultural ways of the American farmer (Bordewich, 1996; Cadwalader & Deloria, 1984; Dale, 1969; Fritz, 1963; Pevar, 1992). It was believed that contact with European Americans and the private ownership of land "... would make farmers out of 'savages,'" as well as hasten the economic self-sufficiency of a people whose former livelihoods had disappeared (Cingolani, 1973; Deloria et al., 1984; Utter, 1993:252).

However, far from helping American Indians, "[t]he effect of the General Allotment Act on Indians was catastrophic. Most Indians did not want to abandon their communal society and adopt the way of life of a farmer. Further, much of the tribal land was unsuitable for small scale agriculture. Thousands of impoverished

Indians sold their parcels of land to white settlers or lost their land in foreclosures when they were unable to pay state real estate taxes. Moreover, tribal government was seriously disrupted by the sudden presence of so many non-Indians on the reservation and by the huge decrease in the tribe's land base" (Pevar, 1992:5). By the time the allotment policies were reversed in 1934 by the Indian Reorganization Act, American Indian land holdings had been reduced by two thirds, from 138 million acres to about 48 million acres (Cingolani, 1973). "At least 200,000 tribesmen either had no land at all or too little for subsistence" (Cingolani, 1973:26).

Though this act was detrimental to the current state of American Indian mental health through its impoverishment of tribes, Washburn (1971) states that "[t]he blow was less economic than psychological and even spiritual" (Washburn, 1971:75).

> No longer did many tribal Indians feel pride in the tribal possession of hundreds of square miles of territory which they could use as a member of the tribe. Now they were forced to limit their life and their vision to an incomprehensible individual plot of 160 or so acres in a checkerboard of neighbors, hostile and friendly, rich and poor, white and red ...
>
> A way of life had been smashed: a value system destroyed. Indian poverty, ignorance, and ill health were the results. The admired order and the sense of community often observed in early Indian communities were replaced by the easily caricatured features of rootless, shiftless, drunken outcasts, so familiar to the reader of early twentieth century newspapers (Washburn, 1971:75).

American Indian Schools

Another major effort toward assimilating American Indians into mainstream American society was the attempt by religious groups and the federal government to "educate" and "civilize" American Indian youth. In 1860, the BIA opened its first "Indian school." By 1887, more than two hundred such schools had been established under federal supervision, with an enrollment of over fourteen thousand American Indian students (Pevar, 1992; Utter, 1993). The goal of these schools was to strip American Indian children of their culture and to replace it with that of mainstream America. Pevar (1992) states that "[t]he history of their authoritarian rule is notorious; for example, students were severely punished if they spoke their native language or practiced their traditions" (Pevar, 1992:4).

The most infamous government school for American Indians was Carlisle. The first off-reservation government boarding school, Carlisle was established in 1879 by a former military officer, Henry Pratt. Pratt's motto was: "Kill the Indian and save the man" (Utter, 1993:196). By the turn of the century, almost half of the American Indian schools under federal supervision were such boarding schools, and American Indian children were routinely forcibly removed from their families to be placed in

them. Though the overt policy of assimilation in this manner was repudiated by 1936, it was not until the 1970s that significant substantive change in the nature of these schools began to occur.

The cultural degradation and social disruptions that resulted from these schools were enormous (Goldstein, 1974; Swinomish, 1991). Swinomish (1991) is very insightful in this regard, and so it is quoted at length:

> Boarding schools were major agents in the loss of Indian languages. Children who were caught speaking Indian languages were rapped on the knuckles or made to stand in corners with rags tied around their mouths. Many children forgot their languages or became ashamed to even admit that they knew them ...
>
> Language is the major carrier of culture ... When the language is lost, a great deal of the culture is lost also. Many things cannot be fully translated. With the words, sounds and rhythm of native speech goes the heart of the culture. *Nothing was done more to weaken Indian culture than attacks on Indian languages made in B.I.A. boarding schools.*
>
> Parents suffered from grief and worry over the fate of their children. They often felt helpless or guilty about not being able to protect their children... *Deprived of their children and of the parenting roles, many families became less stable.* Elders were not able to pass on important family teachings. Some Indian people have suggested that the removal of children to boarding schools contributed to the increase in adult alcoholism on the reservations.
>
> *Many Indian children who spent their formative years in boarding schools grew up unable to fit comfortably into either Indian or non-Indian society.* These children had essentially lost their parents and the chance of a normal family life. They had been subjected to rigorous discipline combined with attacks on their personal and cultural identity, and denied nurturing relationships with any adults ...
>
> *When and if these children returned to their tribes, they often had difficulty fitting into a family and tribal life which they did not completely understand. Having been denied normal Indian childhood experiences and role models, they were delayed in their social and emotional development as Indian people. A large number of these children developed severe problems in adulthood, such as alcoholism, depression and violent behavior.*
>
> *One lasting consequence of the boarding school experience has been an upsurge in child neglect and a cycle of removal of successive generations of Indian children from their parents.* Young Indian parents who had been virtually reared in boarding schools did not learn from their own families how to raise children. In particular, they received the non-verbal message that Indian people could not be good parents. Alienated, angry and depressed, these young parents

> often were unprepared to care for children and to provide their own children with nurturing they had not received themselves. Although the Indian tradition of multiple adult caretakers for all children in the family has been extremely helpful in many cases, it is an inescapable fact of Indian life that entire generations of parents (now for the most part in their middle years) were denied the experience of a normal Indian family life [italics in original] (Swinomish, 1991:35).

American Indian Urban-Relocation

A third major effort toward assimilating American Indians came during the 1950s. Many government officials during this period saw the courageous performance of American Indian servicemen overseas and of American Indian women in the war industries at home, as proof that American Indians were ready for complete assimilation into mainstream American society (Fixico, 1986). Motivated by a desire to alleviate the extreme poverty of American Indians living in tribal communities, an eagerness to terminate the costly services the federal government provided to them, and the patriotic post-war belief that all Americans should conform to middle-class American society, the government implemented a program that encouraged and facilitated the relocation of American Indian people from reservations to urban areas (Fixico, 1986).

Faced with the high unemployment and widespread poverty within tribal communities, curious about city life, and with tribal councils often supportive of the program (because of the poverty of their communities), numerous American Indians enrolled for relocation. By 1956 (about the time of its climax), this program had relocated some 12,625 American Indians to urban areas (from an estimated total tribal-based population of 245,000 American Indians) (Fixico, 1986). However, though the program offered help finding employment and a limited amount of vocational training and financial aid, these things were usually not enough to overcome the drastic social and cultural upheaval to which relocated American Indians were subjected (Fixico, 1986; Swinomish, 1991). "Language differences, social isolation and lack of familiarity with city life led to most relocated Indians returning to the reservation. Others remained in urban areas but developed serious and complex problems" (Swinomish, 1991:24). Fixico (1986) states:

> Federal officials hoped that relocation would assimilate Indians into urban neighborhoods of the dominant society. Instead, Indian ghettos soon resulted ... Such areas fostered feelings of isolation, loneliness, and estrangement for Native Americans. Many resorted to alcohol to escape the competitive and social coldness of highly individualized urbanization. Marital and delinquency problems became acute; broken marriages, school dropouts, and increases in crime were so rampant that discouraged relocatees became severely depressed and sometimes committed suicide. Tragically, a people who traditionally cherished life were now broken in spirit (Fixico, 1986:155).

Though some American Indian people did manage to merge into mainstream American society, relatively few were able to develop a fulfilling blend of American Indian and mainstream beliefs and lifestyle. Many continue today to experience difficulty substituting traditional values for the materialism and competition of modern America (Fixico, 1986; Swinomish, 1991). [15]

American Indian Child Welfare

Prior to the passing of the Indian Child Welfare Act in 1978, mainstream prejudice against American Indian lifestyles and a general lack of understanding of American Indian religious systems and family networks, had led to damaging American Indian child welfare practices by state caseworkers and the non-Indian court system (Kessel & Robbins, 1984; McShane, 1988; Miller, et al., 1980; Swinomish, 1991). "Poverty of Indian families was often interpreted as sufficient cause for the removal of Indian children. Removals were made frequently without sufficient cause and without prior attempts to provide remedial alternatives ... In fact, certain religious groups made it an explicit policy to attempt to remove and 'save' as many Indian children as possible" (Swinomish, 1991:28). By 1977, state child custody proceedings had taken 25 to 35 percent of all Indian children from their homes (Deloria, 1985). In Washington State, the adoption rate for American Indian children was 19 times higher than that of non-Indian children (Byler, 1977). Significantly, these American Indian children were almost always placed with non-Indian foster or adoptive families (Myers, 1981).

This practice had extremely negative effects on American Indian mental health. Swinomish (1991) states:

> The massive removal of Indian children from their families and tribes was devastating not only to the integrity of Indian families and to the psychological and cultural identity of these children, but also to the vitality of entire Indian tribes ... Far from providing these children with an improved chance for a "better life," non-Indian foster care and adoption has generally produced frustrated, confused and angry young Indians without a clear sense of belonging to either Indian or to non-Indian culture. Many developed serious social and emotional difficulties (Swinomish, 1991:28).

Religious Persecution

Colonial governments have, over the course of history, often attempted to suppress the religious beliefs and practices of American Indian communities. These governments considered the diverse American Indian religious beliefs to be pagan, and felt that only by ending these traditional practices and forcing American Indians to accept Christianity would American Indians be transformed into

[15] It is estimated that roughly 56 percent of American Indian people currently reside in urban areas (Grossman, et al., 1994; Shukovsky, 1994).

"civilized" people. The Spaniards outlawed traditional religious practices in 1646, and the U.S. government forbade the practices on reservations in 1883 with the establishment of Henry Teller's "courts of Indian offenses" (Utter, 1993). With the spread of the Ghost Dance Religion in the 1890s, attempts to suppress traditional religious practices reached new heights.

> Built around a prophesy that the world would return to the state it had enjoyed before the coming of the white man and that Indian ancestors and vanished game would reappear, the religious movement offered hope to a population decimated by disease and starvation and imprisoned on reservations. The government saw the religion as a unifying anti-white practice. In 1890 the army massacred three hundred Sioux, mostly women and children, at Wounded Knee, South Dakota. In 1892 the BIA promulgated the Indian Religious Crimes regulation, which made it a crime to engage in any form of Indian dancing or feasting (Deloria, 1985:54).

"Indians were not only fined, but were actually jailed for such 'offenses' as possessing traditional spiritual regalia or participating in a traditional dance ... Indian people who believed in traditional ways were made to feel guilty, primitive and evil" (Swinomish, 1991:31). In the 1920s, official policy against traditional religious practices continued "... when Commissioner of Indian Affairs Charles Burke sent his famous letter 'To all Indians.' Burke urged the Indians to give up 'dances' and 'ceremonies' voluntarily or he might be forced to 'issue an order against these useless and harmful performances'" (Utter, 1993:90). Because of this persecution, "Indians who preserved spiritual knowledge became extremely reluctant to reveal what they knew, and sometimes even that they knew 'anything' at all" (Swinomish, 1991:32). Cultural degradation resulted, and traditional knowledge (including traditional healing knowledge) was lost (Swinomish, 1991).[16]

Conclusion

In this chapter we have presented evidence that the pervasiveness of mental illness among American Indians today (expressed in high rates of depression, alcoholism, and destructive acting-out behavior) is in large part due to a history marked by the subjugation, impoverishment, and cultural degradation of American Indian communities. Furthermore, the difficulties many tribal communities face in dealing with these mental health problems are similarly a product of this history. Many of the methods and networks traditionally employed by American Indian communities to deal with their mental health needs have been disrupted, and to a certain degree destroyed, by the perennial attacks on traditional American Indian ways of life.

[16] Swinomish (1991) notes that "[d]espite pressures to abandon traditional Indian spiritual practices, many beliefs and practices have not died out. They continue to be practiced, to be taught and to affect the world view and value systems of many, if not most Indian people" (Swinomish, 1991:32).

European diseases and United States governmental policies have had the most significant negative impacts in this history. In regard to the latter, the value systems, beliefs and motivations that European Americans have given rise to numerous governmental policies intended to displace American Indians from their lands, and assimilate them into mainstream society. Examples such as the General Allotment Act have seriously impoverished American Indian communities and disrupted their traditional ways of life. In turn, serious and long lasting effects on American Indian mental health have resulted.

Chapter Three: The History of Federal-Indian Policy and the Legal Relationship Between Tribes and the U.S. Government

The history of political and legal relations between American Indian tribes and the U.S. government is extensive, complex and inconsistent. "In the federal area alone, more than 300 treaties have been ratified, more than 5,000 Indian laws passed, more than 2,000 relevant court cases decided, and at least 500 attorneys' general opinions rendered" (Utter, 1993:10). Nonetheless, an understanding of this history is fundamental to the discussion of the mental health needs of American Indians in Washington State, the barriers that prevent those needs from being met, and how MHD and the federal government can more effectively meet those needs. There are three reasons for this. First, the current state of American Indian mental health is intimately connected with this history. Second, the poor state of relations that currently exists between tribal and state governments in Washington State (which is explored in detail in Chapter Five) is in part, a product of this history. Third, this history has endowed many tribes with a unique legal status within American society.

In this chapter we discuss the history of federal-Indian policy, and the legal relationship between American Indian tribes and the U.S. government. This chapter is divided into two sections. In the first section we provide a brief overview of the history of federal-Indian policy. In the second section we explain the current unique legal status of American Indian tribes.

The History of Political and Legal Relations Between American IndianTribes and the U.S. Government

The development of federal-Indian policy can be categorized into six successive eras (Deloria, 1985; Deloria & Lytle, 1984; Getches & Wilkinson, 1986; Pevar, 1992; Swinomish, 1991; Tyler, 1973; Utter, 1993). These eras are:

- Tribal Independence (Pre-1828).
- Removal and Relocation (1828-1887).
- Assimilation and Allotment (1887-1934).
- Reorganization (1934-1945).
- Termination (1945-1960).
- Self-Determination (Post-1960).

Though federal policy has shifted over time, as a whole it has been marked by a "... total lack of Indian involvement or consent in its formulation" (Pevar, 1992:2), and has resembled a slow but constant attempt to either relegate American Indian communities to small tracts of undesirable land and/or destroy them through

dismantling and assimilation. This trend of destruction took a somewhat positive turn with the passing of the Indian Reorganization Act of 1934 (also known as the Wheeler-Howard Act), but in no way did this act represent a complete reversal of the federal government's policy of assimilation. It was not until the presidential campaign of 1960, that the beginning of a clear reversal of federal-Indian policy was evident (Utter, 1993). Since the 1960s, American Indians have been able to begin rebuilding their communities somewhat free of external aggression. In this section, we discuss this history of federal-Indian policy.

Tribal Independence (Pre-1828)

Prior to the arrival of Europeans, more than four hundred independent nations were prospering in what is now the United States (Pevar, 1992).[17] During America's colonial period, some Europeans believed that the indigenous peoples that comprised these nations were without rights, and that by the superiority of European religion and "civilization," colonial powers possessed a natural right to rule over indigenous peoples. However, the predominant view was one that respected tribes as sovereign nations. Colonial powers, it was held, could lay claim to American Indian lands through "the doctrine of discovery," but that claim was only valid against other colonial powers, not against indigenous peoples (Cadwalader & Deloria, 1984; Grossman, 1979; Shattuck & Norgren, 1991; Wilkinson, 1987).

However, this "... recognition of native sovereignty in the Americas was not entirely a matter of altruism ... [the American Indians'] aid, or at least their tolerance, was often essential to the pre-colonial fur traders and, later, to the survival of colonial settlements" (Grossman, 1979:3). Furthermore, colonial powers neither wanted to expend the resources necessary for hostile policies toward American Indians, nor alienate tribes to the advantage of rival colonial powers. Nevertheless, despite the concerns of their mother countries, "[c]olonists generally sought more immediate gains, particularly Indian lands which blocked their paths of expansion ... [In fact, this] tension between mother countries and colonists is an abiding theme in colonial history and contributed much to the eventual independence movements of the colonists" (Grossman, 1979:3).

Not surprisingly, once the U.S. won its independence the concerns of these colonial powers were internalized by the new government. "[N]ot wishing to maintain a standing army and wishing to conserve the nation's resources, the first six Presidents of the United States ... generally pursued a policy of conciliation and

[17] Estimates of the number of independent American Indian nations present in what is now the United States immediately prior to the arrival of Europeans varies among sources. For instance, Segal and Stineback (1977) claim only three hundred nations were present in all of North America. This may be due to the fact that most American Indian communities in pre-Columbian were not part of a social organization that one would properly consider a "nation." Viewing particular American Indian groups as nations was primarily a byproduct of the political demands of Indian-non-Indian treaty-making (Dale, 1969; Fleras & Elliot, 1992).

peace toward Indian tribes" (Grossman, 1979:4). Pevar (1992) notes that prior to 1828,

> the United States government regarded Indian tribes as having the same status as foreign nations and every effort was made to obtain their allegiance. As the U.S. Supreme Court said in 1832, "[t]he early journals of Congress exhibit the most anxious desire to conciliate the Indian nations ... The most strenuous exertions were made to procure those supplies on which Indian friendships were supposed to depend; and everything which might excite hostility was avoided." The Northwest Ordinance of 1787, ratified by Congress in 1789, declared: "The utmost good faith shall always be observed towards Indians; their land and property shall never be taken from them without their consent" (Pevar, 1992:3).

In keeping with this policy, early Presidents recognized tribal sovereignty in treaties and even sent military aid to protect tribes against frontiersmen. Congress respected this sovereignty as well and enacted the Indian Trade and Intercourse Act of 1790 (as well as other, subsequent, legislation), designed primarily to regulate traders and frontiersmen for the protection of tribes. "The federal government of the new nation replaced the colonial mother country as the protector of the Indian tribes and Article I, section 8 of the U.S. Constitution - the 'commerce clause' - recognized this by placing full power over Indian affairs in Congress, denying such power to the states" (Grossman, 1979:4).

Unfortunately, few of these laws were enforced, "... particularly those which might have discouraged settlers from moving west-ward. The government consistently overlooked the forcible and illegal taking of Indian land" (Pevar, 1992:3). This disregard for the taking of American Indian land was motivated primarily by political expediency; U.S. Government policy was meant only to restrain and govern the advance of whites, not to prevent that advance forever. Even those who recognized tribal sovereignty as matter of principle, such as Thomas Jefferson, conceded the inevitability of white expansion and the engulfment of America's Indian population (Grossman, 1979).

Removal and Relocation (1828-1887)

With victories over Great Britain in 1783 and 1815, the accompanying defeat of the eastern tribes in the War of 1812, and the displacement of Spain from Florida in 1819, the pressures on the United States from rival powers were greatly diminished. Subsequently, with less need to foster amiable relations with American Indian tribes and more need to take land from them from for national expansion, federal-Indian policy underwent a significant change (Fritz, 1963; Minugh, Morris, & Ryser, 1989; Prucha, 1985; Shattuck & Norgren, 1991). With the election of Andrew Jackson to the Presidency in 1828, what had already become an unspoken policy of removing eastern tribes to the West became a publicly stated goal.

Two years after Jackson's election, Congress passed the Indian Removal Act of 1830. This act led to the removal of the eastern tribes to the "Great American Desert," which, it was thought, would never be desirable for white settlement (Fritz, 1963). "Through the alteration of persuasion and force, the removal policy resulted in the transportation of the bulk of the eastern tribes beyond the Mississippi River and their establishment on the edge of the Great Plains" (Fritz, 1963:17). However, though these tribes were moved to areas that were promised to them in perpetuity, continued U.S. expansion soon broke these agreements. Many tribes, first relocated to Arkansas, Kansas, Iowa, Illinois, Missouri and Wisconsin, were soon forced to move even farther west to the Oklahoma Indian Territory. With the discovery of gold in California in 1848, which brought thousands of settlers to the West and heightened the desire for American Indian land, the removal policy became more untenable (Shattuck & Norgren, 1991). The United States' answer was to press a formal system of reservations on the tribes. "Reserves were to provide a means of isolating Indians from the base and violent elements of white society while 'good people from Christian missions could teach an appreciation for agriculture, manufacture, and the English language'" (Shattuck & Norgren, 1991:82).

At the same time that the land base of American Indians was being eroded, the federal government began to undermine their status as sovereign nations. Though tribal communities had been considered sovereign while willing to sell land to the U.S., "[w]hen tribes began to realize that no cession - no matter how large or how 'final' - would ever end white demands for more land, they resisted further cessions, and the happy marriage of political convenience and legal principle broke asunder" (Shattuck & Norgren, 1991:113). In an effort to reconcile legal precedent with American expansionist interests, the Supreme Court began to recast tribes as "limited" sovereignties (Minugh, Morris, & Ryser, 1989; Ryser, 1992; Shattuck & Norgren, 1991; Wilkinson, 1987). According to this concept, though American Indians held title to the land they occupied and had a right to self-government, their retention of these rights was at the discretion of the federal government.

The rationale first provided for the recasting of tribes as limited sovereignties was that tribes had their sovereignty diminished by virtue of being "discovered,"[18] and being conquered by the U.S.. By the end of the 1800s, the Court would state that tribal sovereignty had been diminished by virtue of tribal "weakness" in relation to the United States (Cadwalader & Deloria, 1984; O'Brian, 1986; Ryser, 1992; Shattuck & Norgren, 1991). Using as justification the federal government's promise to protect these weaker entities in its treaties with them, the Court recast the federal government's relation to tribes from one of equality to that of a guardian to her wards (Cadwalader & Deloria, 1984; Minugh, Morris, & Ryser, 1989; O'Brian, 1986 Ryser, 1992; Shattuck & Norgren, 1991). "As the Indians' trustee, the federal

[18] With England's defeat in the Revolutionary War, the U.S. was seen as having inherited England's superior title to American Indian land (which had supposedly been gained by discovery) (Shattuck & Norgren, 1991).

government not only assumed the authority to interfere with internal tribal affairs but also asserted the right to dispose of tribal property as it chose" (Shattuck & Norgren, 1991:115).

Assimilation and Allotment (1887-1934)

By the late 1800s, the humanitarian movement that sought to help American Indians through assimilating them into Anglo-American culture, had organized into voluntary associations such as the Women's National Indian Association and the Indian Rights Association. Convinced that the assimilation of American Indians into mainstream society was the only way to save the American Indian race from being extinguished, these groups sought to accomplish this goal by breaking up the communal land bases of tribes and redistributing land to individual tribal members, educating American Indians in the ways of mainstream society, and granting American Indian people U.S. citizenship (Deloria, et al., 1984; Grossman, 1979; Fritz, 1963; Shattuck & Norgren, 1991; Utter, 1993). The first two aspects of this plan were accomplished through the Dawes Act and the Indian schools movement. However, though the Dawes Act originally provided for citizenship to be granted to a limited number of American Indian people, the act was later amended, and it was not until the Indian Citizenship Act of 1924 that U.S. citizenship was universally granted to America's Indian population.[19, 20]

Reorganization (1934-1945)

In 1928, the federal government conducted a major study of the living conditions on American Indian reservations known as the Meriam report. The study "... enumerated the disastrous conditions afflicting Indians at that time: high infant death rates, high mortality rates for the entire population, appalling housing conditions, low incomes, poor health, and inadequate education. The policy of forced assimilation was judged a failure" (Utter, 1993:254).

Due to increased popular concern for American Indian welfare, the obvious failure of the assimilation policy to absorb American Indian communities into mainstream American society, and the reduced European American demand for American Indian land which was precipitated by the Great Depression, the federal government decided to change the direction of its American Indian policy (Pevar, 1992; Kelly, 1986). This change in policy, which came with the passing of the Indian Reorganization Act, was drastic and abrupt. Kelly (1986) writes:

[19] Congress had already, in 1919, made citizens of American Indians who served in the Armed Forces in World War I.

[20] The granting of U.S. citizenship did not annul any rights or other property that American Indians had as members of their tribes; thus they received a type of dual citizenship. Being an American Indian did not annul one's civil rights as protected under the U.S. Constitution, nor did being a U.S. citizen annul any tribal rights an American Indian might have.

> After a century and a half of trying to forcible acculturate and assimilate Indians into American society, during the 1930s the federal government changed its goals dramatically. Under the leadership of John Collier, who served as commissioner of Indian Affairs from 1933 to 1945, the Bureau of Indian Affairs decided to encourage tribal efforts to retain and even revitalize native languages, religious practices, social customs, and forms of artistic expression (Kelly, 1986:242).

The Indian Reorganization Act contained major provisions that ended the policy of allotment and allowed for the reorganization of tribal governments (as well as the investment of those governments with considerable powers). The act consolidated many of the remaining American Indian lands for tribal use, "... made provisions to secure lands for landless Indians, allowed a certain measure of municipal powers with the adoption of a tribal constitution and by-laws, permitted tribes to form business corporations for economic development, established a system of credit for both tribes and individuals, and made Indian preference in employment in the Bureau of Indian Affairs a major goal" (Cadwalader & Deloria, 1984:110). However, the Indian Reorganization Act also mandated a predetermined framework for how tribal governments were to be structured, forcing them to resemble governments familiar to federal policy-makers (Kelly, 1986; Minugh, Morris, & Ryser, 1989; Pevar, 1992). Nonetheless, even though the act "... did not systematically incorporate existing Indian conceptions of authority ... [it] at least in an Anglo-American sense provided an 'individualistic' opportunity to Indian tribes to formulate their own tribal governments and constitutions" (Deloria, 1985:28).[21]

Termination (1945-1960)

From 1945 until 1960, the federal government resumed its policy of assimilating American Indians into mainstream American society. Three methods were used to accomplish this assimilation. The first was an effort to eliminate the unique relationship the federal government had with tribes, and the U.S. Goverment's special responsibilities toward tribes. The second method was the transfer of federal Indian responsibilities and jurisdiction to state governments. The third method was the physical relocation of American Indian people from reservations to urban areas (Fixico, 1986; Pevar, 1992; Utter, 1993).

In 1953, Congress adopted House Concurrent Resolution No. 83-108 (H.C.R. 108) (Fixico, 1986). H.C.R. 108 declared that federal benefits and services to various American Indian tribes should be ended "at the earliest possible time," and called upon the Bureau of Indian affairs to list the tribes that were economically self-

[21] Many American Indians argue that the Indian Reorganization Act was, in fact, far from beneficial or empowering to tribal communities. For instance, in 1989 the President of the Quinault Indian Nation, Joseph DeLaCruz, wrote that "[t]hough apologists for the Indian Reorganization Act thought the law would liberate Indian nations and promote their social, economic and political self-sufficiency, as a practical matter it became the instrument by which the U.S. government assumed greater autocratic rule over Indian Country" (Minugh, Morris, & Ryser, 1989:5).

sufficient enough to survive without benefits. Congress then began "terminating" those tribes, which meant the loss of federal services, the loss of federal recognition of tribal governments, and the loss of tribal immunity from state taxation. During this period, "... Congress terminated its assistance to over one hundred tribes. Each of these tribes was ordered to distribute its land and property to its members and to dissolve its government" (Pevar, 1992:7). In all, approximately 12,000 individual American Indians lost tribal affiliations that included political relationships with the United States (Utter, 1993).

In an effort to further reduce federal responsibility, foster American Indian assimilation, and deal with the ambiguous jurisdiction regarding crime on reservations, Congress passed Public Law 83-280. Generally known as PL 280,

> [t]his statute conferred upon certain designated states full criminal and some civil jurisdiction over Indian reservations and consented to the assumption of such jurisdiction by any additional state that chose to accept it. State governments had long resented the notion of tribal sovereignty and had made repeated efforts to gain control over Indian resources and people. P.L. 280 thus gave powers and responsibilities to the states -the traditional enemy of Indian tribes - that previously had been assumed by the federal government (Pevar, 1992:7).

During this period, the government also instituted a program that encouraged and facilitated the relocation of American Indian people from reservations to urban areas where employment was more plentiful. By 1956 (about the time of its climax), this program had relocated some 12,625 American Indians to urban areas (from an estimated reservation population of 245,000 American Indians) (Fixico, 1986). However, due to the drastic social and cultural upheaval to which relocated American Indians were subjected, many simply returned home (Fixico, 1986; Swinomish, 1991).

Self-Determination (Post-1960)

In the presidential election campaign of 1960, "... candidates John Kennedy and Richard Nixon both pledged there would be no change in treaty or contractual agreement without tribal consent. They also declared there would be protection of the Indian land base, credit assistance, and encouragement of tribal planning for economic development" (Utter, 1993:256). This event marked the beginning of the self-determination era. "Since the late 1960's, Congress has passed a number of statutes that foster Indian self-determination and economic development ... [repudiating] the termination policies of the 1950's. As the Supreme Court noted in 1983, 'both the tribes and the federal government are firmly committed to the goal of promoting tribal self-government, a goal embodied in numerous federal statutes'" (Pevar, 1992:8).

The most important piece of this kind of legislation is the Indian Self-Determination and Education Assistance Act of 1975. This act enabled American Indian tribes to begin divesting themselves of federal control through the strengthening of tribal government. The Self-Determination Act also allowed tribes the authority to administer the federal programs operating on reservation land. The act "... reflects a fundamental philosophical change concerning the administration of Indian affairs: tribal programs should be funded by the federal government, but the programs should be planned and administered by the Tribes themselves; federal 'domination' should end" (Getches & Wilkinson, 1986:154).

Three years later, in 1978, Congress passed two other significant acts that helped to strengthen tribal self-determination and sovereignty. One act was the Indian Child Welfare Act. Designed to stem the flow of American Indian children out of American Indian homes and tribal communities, the Indian Child Welfare Act established:

> ... standards for the placement of Indian children in foster or adoptive homes in order to prevent the breakup of Indian families. It establishes minimum federal standards for the removal of Indian children from their families and the placement of such children in foster or adopted homes that will reflect the unique values of Indian culture and provide for assistance to tribes in the operation of child and family service programs. It gives Indian tribes jurisdiction over Indian children, and takes jurisdiction away from states, transferring it to the tribes and tribal courts (Miller, et al., 1980:470).

The second significant act was the American Indian Religious Freedom Act. In 1883, the U.S. government forbade traditional American Indian religious practices on reservations (Utter, 1993). "Indians were not only fined, but were actually jailed for such 'offenses' as possessing traditional spiritual regalia or participating in a traditional dance" (Swinomish, 1991:31). The American Indian Religious Freedom Act prohibits such persecution and ensures that state and federal agencies will no longer infringe upon the first amendment rights of American Indians to exercise traditional religious practices.

Since Nixon, tribal self-determination has been encouraged by Presidents Ford, Carter, Reagan, Bush, and Clinton (Getches & Wilkinson, 1986; Utter, 1993; U.S. Government, 1995). President Reagan, for instance, declared: "[T]his administration intends to restore tribal governments to their rightful place among governments of this nation and to enable tribal governments, along with state and local governments, to resume control over their own affairs" (Pevar, 1992:9).

The Legal and Political Status of American Indiansand Tribal Governments

Many American Indian tribes have reserved both land and a unique legal status within the American political system. Initially this was achieved through treaty. After 1871 (when the United States renounced formal treaty making with tribes), this was accomplished through congressional statutes and through the Interior Department acting pursuant to delegated authority from Congress (Cadwalader & Deloria, 1984; Pevar, 1992; Utter, 1993; Wilkinson, 1987). From 1855 to 1919, tribes reserved land and a unique legal status through executive order (Pevar, 1992; Wilkinson, 1987). However, with minor exceptions, the Court has not distinguished among these methods in its consideration of reserved tribal land and legal rights, viewing them as legally comparable (Cadwalader & Deloria, 1984; Pevar, 1992; Utter, 1993; Wilkinson, 1987). This section discusses the most pertinent aspects of the unique legal status that many American Indian tribes secured in these three ways.

Tribes as "Domestic Dependent Nations"

The term "domestic dependent nation" was first used in 1831, in the Supreme Court case *Cherokee Nation v. Georgia.* At the time, it was meant to express the anomalous legal status American Indian tribes had obtained as a result of the loss of their sovereign right to form political and legal relationships with nations other than the United States (Cadwalader & Deloria, 1984; Shattuck & Norgren, 1991). Though American Indians often justifiably argue that such an abrogation of inherent rights was impossible without their consent, this abrogation was nevertheless in accordance with the doctrine of discovery, a legal canon widely accepted by European nations (Cadwalader & Deloria, 1984; O'Brian, 1986; Shattuck & Norgren, 1991). However, as was touched on in the previous section, by the end of the nineteenth century, the Court had abandoned legal precedent by using the tribes' domestic dependent nation status to transform its conception of tribes from nations sovereign in all aspects except the one mentioned above, to groups whose sovereignty existed only at the discretion of the federal government (Cadwalader & Deloria, 1984; O'Brian, 1986; Pevar, 1992; Ryser, 1992; Shattuck & Norgren, 1991; Wilkinson, 1987).

One ramification of this transformation is the view that the federal government gained a title, superior to that of American Indians, to all land claimed by the United States (regardless of whether or not individual tribes had formally ceded that title) (Cadwalader & Deloria, 1984; Pevar, 1992; Shattuck & Norgren, 1991; Wilkinson, 1987). The tenets of American Indian land title that this transformation engendered are:

> (1) the federal government acquired ownership of all land within the United States by discovery and conquest, (2) Indians retain a perpetual right to live on their ancestral homeland until such time as Congress decides to take this land for another purpose, (3) Indian title is a possessory interest, that is to say, Indians have a right to possess their ancestral homelands but not to own it unless Congress gives them title to it, and (4) Indian title cannot be sold by the Indians or bought by anyone else without authorization from the federal government (Pevar, 1992:20).

Though the Court has chosen to undermine American Indian sovereignty in this manner, it nonetheless continues to view Federal-Indian treaties (and the treaty substitutes discussed in the introduction to this section) as similar in character to those treaties that the federal government makes with foreign nations. The Court also considers both the making and breaking of treaties to be solely at Congress' discretion and beyond judicial review. As a result, Congress is seen as having the ability to eliminate both the land title and the unique legal rights American Indian tribes have reserved through treaties and treaty substitutes. Congress is viewed as having plenary power (nearly absolute power) "... over all Indian tribes, their government, their members, and their property" (Pevar, 1992:48). Congress' plenary power allows it "... to legislate for the Indian tribes in all matters, including their form of self-government" (U.S. v. Wheeler, 435 U.S. 313).

However, though the Court has decided not to limit the scope of political choices open to the federal government in relation to tribes, it does insist that the implementation and administration of such policies that the federal government has chosen to adopt conform to "... legal standards of regularity, calculability, and due process consistent with liberal principles of formal legal rationality" (Shattuck & Norgren, 1991:191). In accordance with this, the Court has established legal rules insisting that unclear treaty language be interpreted in favor of the American Indian signatories, and that Congressional treaty abrogation be explicit and done with full notice (Shattuck & Norgren, 1991). The Court has also established (in conformity with the Just Compensation Clause of the Fifth Amendment to the U.S. Constitution) that if Congress deprives a tribe of land or vested rights that were reserved by an act of Congress, the government must compensate that tribe for the loss (Pevar, 1992; Shattuck & Norgren, 1991; Wilkinson, 1987).

The Court further insists that the federal government's dealings with tribes conform to its "trust responsibility" toward them (Canby, 1981; Getches & Wilkinson, 1986; Pevar, 1992). In regard to this responsibility, Canby (1981) states:

> At its broadest, the relationship includes the mixture of legal duties, moral obligations, understandings and expectancies that have arisen from the entire course of dealing between the federal government and the tribes. In its narrowest and most concrete sense, the relationship approximates that of trustee and beneficiary, with the trustee

> (Federal Government) subject in some degree to legally enforceable responsibilities (Canby, 1981:32).

The doctrine of trust responsibility obligates the federal government to fulfill the explicit commitments it has made to American Indian tribes in treaties, federal statutes, agreements, and executive orders (Getches & Wilkinson, 1986; Pevar, 1992). To a lesser degree, it also obligates the government to fulfill implied commitments (Pevar, 1992). Finally, it also imposes on the federal government a duty to "...remain loyal to Indians and to advance their interests, including their interest in self-government" (Pevar, 1992:27). In regard to this, a 1977 Senate commission stated that:

> The purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people. This includes an obligation to provide those services required to protect and enhance Indian lands, resources, and self-government, and also includes those economic and social programs which are necessary to raise the standard of living and social well-being of the Indian people to a level comparable to the non-Indian society (American Indian Policy Review Commission, 1977:130).

Federally Recognized Tribes

The federal government does not recognize all American Indian tribes. In fact, "...the federal government officially recognizes less than three hundred of the more than four hundred tribes that claim to exist" (Pevar, 1992:14). This lack of recognition can result from: the failure of the federal government to have, at some point, created a reservation for the tribe; the loss of tribal identity or a unifying tribal leadership; or federal termination of tribal status (as explained in the previous section) (Pevar, 1992). Currently, only twenty-nine of the thirty-six tribes in Washington State are federally recognized.[22] Federal recognition is significant because only federally recognized tribes are eligible for most federal-Indian programs (Pevar, 1992; Utter, 1993). Furthermore, only federally recognized tribes maintain governments that exist beyond state jurisdiction (Pevar, 1992; Utter, 1993).

[22] The federally recognized tribes in Washington State include the Chehalis, Cowlitz, Hoh, Jamestown S'Klallam, Kalispel, Lower Elwha S'Klallam, Makah, Muckleshoot, Snoqualmie, Nisqually, Nooksack, Port Gamble S'Klallam, Puyallup, Quileute, Samish, Sauk-Suiattle, Shoalwater Bay, Skokomish, Spokane, Squaxin Island, Stillaguamish, Suquamish, Swinomish, and Upper Skagit Tribes, as well as the Lummi Nation, the Quinault Nation, the Yakama Indian Nation, the Colville Confederated Tribes, and the Tulalip Tribes. The tribes in Washington State that lack federal recognition are the Chinook, Duwamish, Kikiallus, Snohomish, Snoqualmoo, Steilacoom, and Marietta Band of Nooksack Indians.

State Jurisdiction Over "Indian Country"

The term "Indian country" denotes all land within the boundaries of a federal Indian reservation, all land outside of reservation boundaries that is owned by American Indians and held in trust or restricted status by the federal government, and all other lands set aside for the residence of tribal-based American Indians under federal protection (known as "dependent Indian communities") (Pevar, 1992; Utter, 1993; 18 U.S.C. Sec. 1151). In general, states do not have any jurisdiction over Indian country unless Congress has granted such jurisdiction (Pevar, 1992). However, the Court has declared that states can nonetheless assert jurisdiction if such an assertion does not violate federal law, does not interfere with overriding federal or tribal interests, and does not interfere with tribal self-government (unless the state interest in doing so is very compelling) (Pevar, 1992; State of Washington, 1977; *Moe v. Confederated Salish and Kootenai Tribes*, 425 U.S. 463).

In accordance with this judicial declaration, though tribes have civil jurisdiction within Indian country over both American Indians and virtually every non-Indian activity that involves American Indians or American Indian property, the Court has granted states some civil jurisdiction over certain activities involving non-Indians within Indian country (Cadwalader & Deloria, 1984; Pevar, 1992; State of Washington, 1977; *Moe v. Confederated Salish and Kootenai Tribes*, 425 U.S. 463). For example,

> ... the Court has permitted states to require Indian merchants to collect a state sales tax from their non-Indian customers ... The state can also require Indian merchants to keep records of their sales to non-Indians for state taxation purposes. Likewise, a non-Indian who wishes to sell liquor on the reservation can be required to obtain both a tribal and a state liquor license, and any personal property a non-Indian owns on the reservation can be taxed by the state as well as the tribe (Pevar, 1992:160).

In regard to state criminal jurisdiction in Indian country, the Court has only allowed this to include crimes committed by non-Indians against other non-Indians (Pevar, 1992).

Congress has, however, expanded the jurisdiction of a number of states. This expansion has mainly occurred through PL 280, which mandated that six particular states assume, with limited exceptions, complete criminal jurisdiction and some civil jurisdiction over the American Indian reservations within their boundaries. PL 280 gave other states the option of doing so as well.

Washington accepted this option, receiving full jurisdiction over all fee patent land within Indian country, as well as limited jurisdiction over all American Indian land held in trust by the federal government (fee patent land is land held with full rights of ownership by an individual, as opposed to trust land, in which ownership is

retained by the federal government).[23,24] Washington's jurisdiction over trust land is limited to compulsory school attendance, public assistance, domestic relations, mental illness, juvenile delinquency, adoptions, dependent children, and the operation of motor vehicles on public roads (GOIA, 1991; Pevar, 1992; Swinomish, 1991). However, this state jurisdiction is not exclusive, but concurrent with tribal jurisdiction, and in regard to civil issues, Washington State jurisdiction has only been expanded to the degree that its courts are now permitted to resolve private disputes brought to it by American Indians who reside in Indian country (Pevar, 1992; State of Washington, 1977; Wilkinson, 1987).

Health Care

As U.S. residents, American Indians are entitled to participate in state and federal health care programs on an equal basis with all other residents. American Indian people also often participate in health care programs funded by their tribes. Furthermore, they are eligible for a number of federal programs designed to fulfill treaty obligations and the federal government's trust responsibility.

Many tribes have treaties with the United States in which medical supplies and physician services were promised (National Summit on Indian Health Care Reform, 1993; Pevar, 1992). For instance, the 1854 Medicine Creek Treaty between the United States and Washington's Nisqually, Puyallup, Steilacoom, Squaxin, Samamish, Stehchass, T'Peeksin, Squiatl and Sahehwamish Tribes states: "... the United States further agree to employ a physician to reside at the said central agency, who shall furnish medicine and advice to their sick, and shall vaccinate them; the expense of the said ... medical attendance, to be defrayed by the United States, and not deducted from annuities."[25]

Over and above the federal government's treaty obligation to provide medical care for certain tribes, it is further obligated to provide for American Indian health care needs because of its trust responsibility toward them (National Summit on Indian Health Care Reform, 1993; Pevar, 1992). The first effort by Congress to improve general health care for American Indians was the Snyder Act of 1921. "This law authorizes the expenditure of federal funds 'for the relief of distress and conservation of health of Indians'" (Pevar, 1992:275). However, it was not until 1976, and the passing of the Indian Health Care Improvement Act, that Congress

[23] Washington State can assert complete jurisdiction within an American Indian reservation at the tribe's request. Currently, only a very limited number of tribes remain under complete Washington State jurisdiction (GOIA, 1991; Pevar, 1992).

[24] A few tribal reservations in Washington State, such as those of the Upper Skagit and Sauk-Suiattle, do not fall under Washington State jurisdiction through PL 280 because the reservations were formed after PL 280 went into effect in this state.

[25] Language within this particular treaty is ambiguous as to the duration that the federal obligation to provide such medical services was to last twenty years or indefinitely. However, as stated above, the Supreme Court has stated that ambiguous treaty language is to be interpreted in favor of the American Indian treaty signatories.

gave its first specific acknowledgment of the federal government's special responsibility for American Indian health services (National Summit on Indian Health Care Reform, 1993; Pevar, 1992). The act states: "The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy" (25 U.S.C. Sec. 1602).

Tribes as Entities Outside of the Federal Governmental System

Many people still question the federal government's right to assert jurisdiction over American Indian tribes (Deloria, 1969; Deloria, 1974; Josephy, 1971; Minugh, Morris, & Ryser, 1989; Pevar, 1992; Prucha, 1984; Ryser, 1992). It is argued that tribes were sovereign nations long before the United States, and there is no language within most federal-Indian treaties that would suggest that tribes renounced their sovereignty through them. As was addressed above, the United States acknowledged this fact until expansionist interests began to dictate otherwise. Subsequently, it is argued that American Indian tribes exist outside of the U.S. federal system and that the federal government's control over American Indian communities "... is quite simply illegal under international law ... [F]ederal 'Indian law' is not and was never so much a matter of law as it is and was always an exercise in rationalizing the extension and maintenance of U.S. colonial domination over every indigenous nation it encountered" (Minugh, Morris, & Ryser, 1989:53)

Conclusion

Until recent decades, federal-Indian policy has primarily been motivated by the United States' desire to displace American Indians from their land and assimilate them into mainstream society. As was discussed in Chapter Two, these efforts to displace and assimilate American Indians have had drastic effects on American Indian communities and, subsequently, on American Indian mental health. Since the 1960s however, federal-Indian policy has increasingly supported tribal self-government and the strengthening of tribal communities.

The United States' historical desire to displace American Indian tribes from their lands has also resulted in federal courts effectively undermining the sovereignty of tribes, while providing them with a unique legal status within the U.S. federal governmental system. The unique legal status that tribes hold is that of domestic dependent nations, toward which the federal government has special responsibilities, and over which it has plenary power. Many American Indians argue however, that tribes never relinquished their sovereignty to the United States, and that such an assertion of U.S. jurisdiction over them is a form of

colonial tyranny. The ramifications of this unique legal status and the controversies that surround it, (as they pertain to American Indian mental health) are discussed throughout the rest of this document.

Chapter Four: The State of Mental Health of American Indians in Washington State

In this chapter we present what is currently known of the state of mental health of American Indian people in Washington State. For this discussion, we draw from studies that have been conducted across the nation to get a general sense of the state of mental health of American Indian people. In addition, statistics and other data gathered from IHS, MHD, DOH, DASA, American Indian mental health programs and other sources, will be presented as a means of describing what is known about the state of mental health of American Indian people in Washington State. However, prior to this review of the mental health status of American Indians in Washington State, we discuss the reasons why there is not presently a reliable set, or source, of data describing this mental health status.

Statistics and the Importance of Tribal Control of Data

Presently, there is not a reliable set, or source, of data describing the mental health status of American Indians in Washington State. Without accurate data, the ability for American Indian mental health care programs to plan, develop policy, monitor program quality, and improve services is diminished. In addition, a lack of data puts these programs at a distinct disadvantage when competing for grants and other funding. It is difficult, if not impossible, for the programs to clearly demonstrate the need for services and funding without presenting at least rudimentary data to potential funding agencies.

There are two fundamental reasons for this lack of reliable data; the first reason is cultural, the second systemic. In regard to the first, American Indian people have traditionally utilized oral rather than written forms of communication. The knowledge of a tribe's language, religion, history and other traditional ways of life are passed from one generation to another through story-telling and teachings from the elders of the community. Since contact with colonial governments, many American Indian people have become esteemed authors of the written word; however, in a general sense, American Indian people maintaining written records (including data) about their tribes is not culturally congruent with traditional American Indian beliefs.

Another culture-based barrier to the existence of reliable data is that some mental health problems that affect American Indians are not formally recognized by Western science. Furthermore, mental illnesses in American Indian communities are commonly viewed as being interrelated with the physical body, spirituality, and the physical environment (Guilmet & Whited, 1989; Swinomish, 1991); as a result, mental illnesses in American Indian populations are not easily described or quantified.

The most widely used psychiatric diagnostic manual, the *Diagnostic and Statistical Manual, Revised* (DSM IV) of the American Psychiatric Association, is the best diagnostic reference available for American society as a whole, but has limited relevance to American Indian clients because the guide does not recognize certain types of mental illnesses common in American Indian communities. Very limited work has been conducted in the diagnosis and classification of mental illnesses among American Indian populations (Neligh, 1990; Trimble & Lafromboise, 1985). Due to the lack of a clear methodology (manual) for providers to diagnose and classify mental illnesses in American Indian clients, it is hard, if not impossible, to generate statistical data (rates and prevalence) that accurately describes the overall mental health status of a particular American Indian tribe.

The second reason why there is not a reliable data set, or source, is that the four general locations from which American Indian people in Washington State receive mental health services (RSN contracted providers, IHS run facilities, urban-based programs, and tribal-based mental health care programs) keep limited data in regard to the mental health of their clients.[26, 27, 28] For example, RSNs are required by law to collect statistical data on services provided to their client populations. However, the data that the RSNs are responsible to keep deals primarily with parity to ensure that ethnic groups statewide are equally served.[29] IHS keeps a limited array of data that is inadequate in drawing a clear picture of the mental health status of American Indians in Washington State.

The extent to which American Indian mental health programs maintain statistical data on their clients varies from one program to another. Most American Indian mental health programs do not keep statistical data at all (Steenhout, 1996). At some American Indian mental health programs, especially larger programs, it is standard procedure to keep data on clients (Guilmet & Whited, 1989; Steenhout,1996; Swinomish, 1991). However, this data is often kept as a direct result of reporting requirements from outside funding agencies, and generally only address numbers of clients served and types of services provided.

In general, the extent to which an American Indian mental health program is able to maintain data is greatly governed by a program's access to funds. The majority of the funds that most American Indian mental health programs receive are used to pay for direct service delivery, not general program and administration costs, or research. Maintaining accurate data is costly and takes considerable technical

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[26] Furthermore, these different mental health programs have no formally established link with one another, thereby fragmenting available data.

[27] The prevalence of dual diagnoses in Indian country adds an additional complexity to maintaining accurate data.

[28] It is the opinion of several professionals who took part in this research effort that the SIHB keeps the best data of these four locations. However, during this research effort, we were unable to gain an accurate picture of what types and to what extent, the SIHB keeps data on its clientele.

[29] Parity is the proportion of a total population whom a group represents, compared to the proportion that group represents of the total population served—with equal ratios being the goal.

skill. When an American Indian mental health program is under-funded, which is generally the case for all American Indian mental health programs in the State of Washington, maintaining statistical data on its clients becomes a limited priority. When an American Indian mental health program does keep data, it is usually accomplished in a flexible, non-intrusive format. "Record keeping for a culturally oriented mental health program serving Indian clients in a tribal community setting must be kept simple, minimally intrusive and maximally congruent with tribal community values. Record keeping is an area of inherent difficulty." (Swinomish, 1991:321).

In addition, when American Indian mental health programs do maintain statistical data, it is absolutely necessary that the tribe retain partial, if not total, control over the information. Tribal control of data is fundamental to tribal self-determination. Throughout the history of Indian-non-Indian relations in this country, information generated about American Indian communities has, in some cases, been used against tribes and their interests. As such, many tribes are wary of maintaining data and are particularly wary of sharing tribal data with outsiders.

In recent interviews, nearly every tribe in the State of Washington communicated that they would be interested in participating in a statewide data collection effort to compile basic mental health care statistics for grant writing, policy development, and lobbying purposes. However, most of those interviewed emphasized that the process would need to be low-impact on staff time, the collection process designed by tribes, and the data controlled by tribes and/or an American Indian organization.

The Mental Health Status of American Indians in Washington State

"In Indian mental health, the problems are of a diverse nature, with different degrees of severity, causes, courses, and effective treatments. This diversity is reflected in the complexity in the tasks and duties of the Indian mental health programs themselves" (Neligh, 1990:25). Many types of mental illness that are common in some American Indian communities are generally unrecognized by Western science (Gregory, 1991; Guilmet & Whited, 1989; Hahn, 1978; Jilek, 1974a, 1974b, 1982; Marano, 1982; Neligh, 1990; Shore & Mason, 1981, 1983; Swinomish, 1991; Trimble, et al., 1983). For example, one would not find a description of Ghost Illness in a Western psychiatry diagnostic manual.

> Ghost illness appears to be a culture bound syndrome. Spirits or "ghosts" may be viewed as being directly or indirectly linked to the etiology of an event, accident, or illness, and this may occur irrespective of biomedical etiologic views. Western languages lack formal terminology for ghost illness, and the parallel beliefs and behaviors are masked by and hidden within Western social fabric as well as the paradigms of Western psychiatry and medicine (Putsch, 1990:4).

Like mainstream mental health programs, American Indian programs employ the most widely used diagnostic manual, the DSM-IV, in daily practices; most mental health providers at American Indian mental health programs were formally trained in Western universities. "The DSM III-R [DSM-IV] represents the consensus of professionals from several mental health disciplines about the diagnostic categories and criteria for these diagnoses among American people. Although it is not perfect nor always perfectly phenomenological, it is currently the best available diagnostic system for use with the American population as a whole" (Neligh, 1990:25). However, the DSM-IV has limited relevance to American Indian people; generally, the extent to which this manual applies to an American Indian client depends on the client's level of acculturation into mainstream society. "In considering the diagnosis of mental illness among American Indians, it is doubtful that the DSM III-R [DSM-IV] is in all ways applicable" (Neligh, 1990:25).

As mentioned earlier in this document, it is important not to generalize about the state of mental health in American Indian communities. Many studies have shown that rates and levels of mental illness vary significantly from one tribe to another (Berlin, 1987; Dizmang, et al., 1987; Holmren, et al., 1983; May & Dizmang, 1974; Shore, 1974; Shore & Mason, 1983). For example, Shore (1974) discovered that the suicide rates for American Indians varied between tribes from "... eight to 100 per 100,000. This emphasizes the importance of the tribal-specific nature of certain behaviors—in this case, suicide, which should not be represented as 'an Indian problem'" (Shore, 1974:63). Likewise, with regard " ... to both alcohol usage and alcohol related problems, an extremely wide variation exists among Indian tribes, and among individual Indians. Thus statements about Indians and alcohol should specify which Indians, in what place, during what period, and under what circumstances" (Westermeyer, 1974:36).

Nationally, American Indians do appear to be at higher risk for mental health problems such as depression, substance abuse, domestic violence and suicide, when compared with other ethnic groups. (Berlin, 1987; May & Dizmang, 1974; Nelson, 1991; Nelson, et al, 1992; Van Winkle, 1981). It has been found on a national level that:

- Suicide rates among American Indian males are two to four times higher than the national average (Debruyn, et al., 1988; Debruyn, Hybaugh, & Valdez 1988; Johnson, 1994; Manson, et al., 1989; May, 1987; May & Dizmang, 1974; Nelson, et al., 1992; U.S Congress, 1990).
- Heavy alcohol use and suicide in American Indian communities can be attributed to (correlated with) factors such as racism, poverty, unemployment, and marginal economic status (Beltrame and McQueen, 1979; Berlin, 1987; Manson, et al., 1989; Westermeyer, 1974).
- Heavy alcohol use has been found to be a factor in 90 percent of all suicides by male American Indian adolescents and adults (Berlin, 1987; Johnson, 1994).

- Mental health professionals working in American Indian mental health programs believe that many single-vehicle accidental deaths are actually suicides (Berlin, 1987; Neligh, 1990; Nelson, et al., 1992; Swinomish, 1991).
- A phenomenon of mental health problems being interrelated with one another is present in American Indian communities (Berlin, 1987; Dinges & Duong-Tran, 1993; Gregory, 1991; Johnson, 1994; Manson, et al., 1989; May, 1987).

"Other common mental health problems of Native American individuals are major anxiety, including panic disorders; psychosomatic symptoms; and emotional problems resulting from disturbed interpersonal and family relationships" (Nelson, et al., 1992:257).

American Indian children and adolescents are at particularly high risk of mental health problems (Bechtold, 1988; Berlin, 1987; Inouye, 1993; Lake, 1982; Manson, et al, 1989; May, 1987; Nelson, 1991). In 1990, the U.S. Congress, Office of Technology Assessment, published a document entitled *Indian Adolescent Mental Health*, that addressed the state of mental health among American Indian youth. This comprehensive and highly respected document (especially among the providers of mental health services to American Indian adolescents), revealed that:

> ... Indian adolescents have more serious health problems than do any other group in the nation. These problems include developmental disabilities; depression; poor self-esteem and alienation; running away from home; dropping out of school; anxiety; alcohol and substance abuse; and suicide. The report also disclosed that resources to cope with these problems are clearly inadequate. There are over 397,000 children and adolescents in Indian Health Services (IHS) service areas. Yet IHS funds only 17 mental health providers trained to treat children and adolescents—and average of one provider for every 23,353 youngsters. At least 200 more mental health workers are needed to achieve parity with the mental health services available to the general population (Inouye, 1993:7).

Dizmang, et al. (1974) conducted a study in which the researchers interviewed the families, extended families, friends and teachers of American Indian young adults who had committed suicide, in order to explore the etiologic factors involved; they discovered that:[30]

- 70 percent of the suicide group had more than one significant parent or caretaker before age 15, compared to 15 percent of the control group.
- 50 percent of the suicide group had experienced two or more losses by divorce or desertion, compared to 10 percent of the control group.

[30] The experimental group was made up of a sample of 10 American Indians between the ages of 15 and 24 living on the Fort Hall reservation in Idaho, who had committed suicide. The control group was chosen by stratifying the sample on a basis of age, sex, degree of Indian blood, and no known suicide attempt by the control member or anyone in his/her immediate family prior to the death of the matched suicide subject. A control group consisting of four individuals matched by the above variables was selected for each of the ten suicides.

- 40 percent of the parents or caretakers of the youth in the suicide group had had five or more arrests, compared to 7.5 percent of the control group.
- 80 percent of the suicide group had been arrested one or more times in the 12 months prior to death, compared to 25.5 percent of the control group.
- 60 percent of the suicide group had attended boarding schools prior to the ninth grade, compared to 27.5 percent of the control group.

Berlin (1987) conducted an extensive review of the literature addressing patterns of suicide in American Indian adolescents and concluded the following:

- Adolescents who were adopted by non-Indian parents or attended boarding schools, had especially high suicide rates (and drop-out rates).
- Generally, adolescents from tribal communities that were more traditional tended to have a lower prevalence of alcoholism, depression, and suicides.
- Adolescents were more likely to commit suicide if they lost a close family member to death, divorce, or desertion (including loss of parental involvement because of alcoholism).
- Early recognition of depression lessened suicide rates among adolescents.
- Suicide rates among adolescents were lower among those who were in close contact with tribal elders and involved in community events.

Many of the "... most serious environmental risk factors associated with high rates of mental health problems in children and youth—poverty, minority ethnic status, parental psychopathology, physical and other maltreatment—can be observed in Native American communities" (Nelson, 1991:1050). Furthermore, American Indian youth who are removed from their homes are much more likely to suffer from mental health problems thereafter (Berlin, 1987; U.S. Congress, 1990). Strikingly, Unger (1977) found in a survey of states with large American Indian populations, that 25 to 35 percent of all American Indian children were removed from their families and placed in foster care. In Washington State, Shore (1978) discovered that American Indian children were over nine and a half times more likely to be placed in foster care than non-Indian children.

Depression seems to be the most common mental disorder among both young and adult American Indians (Neligh, 1990; Nelson, 1991). Significantly, researchers have discovered that many "acting-out" type problems, such as suicide, assault, homicide, sexual abuse and domestic violence (and other forms of family conflict), are closely connected with depression (Johnson, 1994; Neligh, 1990; Nelson, 1991; Swinomish, 1991). Furthermore, substance abuse, anxiety, low self-esteem and poor performance in school, have been linked to depression as well (Johnson, 1994; Neligh, 1990; U.S. Congress, 1990; Swinomish, 1991). Similar to national trends, the rate of depression among American Indians in Washington State seems to be very high (Gregory, 1991; Guilmet & Whited, 1989; Steenhout, 1996; Swinomish, 1991). Speaking before the Committee on Interior and Insular Affairs (U. S. House

of Representatives), concerning the levels of depression in Washington State American Indian populations, an employee of MHD stated:

> ... the rate of depression [among Washington State Indian populations] is extremely great. I am also particularly concerned about the amount of what I am going to call dual diagnosis--Indians that have mental illness with chemical use, substance abuse[31] ... incidents of depression, suicide, sexual abuse, unemployment, domestic violence, and other violent crimes remain extremely high. Most Indians suffer from loss of positive cultural identity, loss of family and traditional support systems, loss of traditional experiences and leadership. Most Indians live in a cultural 'no man's' land. They have not adapted to mainstream cultures and have been far removed from their own traditional belief and practices (Blair, 1990:285).[32]

The mental health problems found in American Indian populations in Washington State, similar to national trends, can generally be characterized by:

- "Multiple and interacting family, financial, physical, legal and psychological problems...
- Acute symptoms often being masked by related problems, such as alcoholism, delinquency, violence or physical illness ...
- Diagnosis being complicated by different cultural values and symptom patterns ...
- The pervasiveness of depression in American Indian communities ...
- A tendency to experience emotional and psychological problems as either physical illness or as caused by external stress only" (Swinomish, 1991:45)

Gregory (1991) made substantial observations about mental health problems among American Indian populations in Washington State; this is one of the only studies discovered during this research process that discusses mental problems by diagnosed disorder, so we quote it at length:

- "Major mental illness such as schizophrenia and bipolar disorder seem to occur at rates slightly below those experienced in the general population ...
- Major depression and dysthymic disorder (a less severe, more chronic depression) are common among American Indians in Washington State ...
- Demoralization, a diagnosis not in the DSM-III R (DSM-IV), is even more common, especially in the urban Indian population which is to a substantial degree both disadvantaged and alienated ...
- Major depression and dysthymia often occur together in the same individual in a so-called 'Double Depression.' Grief reactions and bereavement, occur secondary to very frequent traumatic life events. While these conditions most often

[31]Verbal testimony.
[32]Written testimony.

resolve, they can evolve into a major depression or they may complicate dysthymia ...

- While suicides among depressed or dysthymic Indian elders are rare, suicides among Indian adolescents and young adults, especially males, are common. Substance abuse is one of the most important risk factors in most of the youth suicides ...
- Post traumatic stress disorder (PTSD), as a result of early and prolonged physical, sexual and/or emotional abuse, is one of the most common problems encountered. This abuse is a legacy of transgenerational trauma inflicted on American Indians, including the often deliberate introduction of alcohol, ongoing poverty and unemployment, and the deliberate breaking down of culture and community in the name of acculturation ...
- Personality disorders occur in Native Americans augmented as a result of family dysfunction and relationship problems, substance abuse, and historical traumatization ...
- Trauma, especially from motor vehicle accidents and domestic violence (and other fighting incidents), produces traumatic brain injuries (TB's) which present ... everything from learning disabilities and behavior problems, especially impulse control, to quadriplegia ...
- Substance abuse which causes FAS/FAE and other encephalopathies, is common and is a major factor in both pre-natal and traumatic damage to cerebral function ...
- Dual diagnosis, the coexistence of a mental disorder and a substance use/abuse/dependence disorder, is very common. A substance abuse disorder in the absence of an unresolved mental health problem is rare" (Gregory, 1991:3-4).

Neligh (1990) estimates the prevalence of emotional disorders in the "serious" range among American Indian children nationwide to be roughly 25 percent. In 1986, a study entitled *Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children*, estimated that between 11 to 20 percent of Indian children in Oregon, Washington and Idaho, are seriously emotionally handicapped, developmentally disabled, or both (Cross, 1986). Regarding Washington State in particular, a study entitled the *Washington State Children's Mental Health System Analysis* (commonly referred to as the *Trupin Study*) found that 17.6 percent of American Indian youth in the public school system suffered from a severe emotional disorder (SED) (Trupin, et al., 1988). The rate of SED among American Indian children was substantially higher than SED rates among African-American (7.3 percent), Hispanic (4.1 percent), and Asian-American (1.6 percent) children.[33] Another significant finding of the *Trupin Study* was that 94.1 percent of all SED children were not receiving State-funded mental health services (Trupin, et al., 1988).

[33]Trupin noted that because of small sample sizes, prevalence estimates were not overly stable.

In recent interviews with seventeen Tribes in the State of Washington that have mental health programs, clinical staff noted that they were observing a very high level of co-occurring disorders, or dual-diagnosis, among their service population. On average, programs estimated that between 70-90 percent of their service population suffered from dual diagnosis disorders. Additionally, the majority of these professionals felt there were no viable inpatient options for American Indian dual-diagnosis clients requiring hospitalization in the State of Washington.

American Indians receive mental health services from two parallel systems, the IHS system (direct service from IHS, programs operated by the tribes, and urban-based programs), and the RSN system. IHS spends less than 2 percent of its annual budget on mental health and does not scratch the surface of the mental health service needs of American Indians; of the limited services that are provided, urban-based American Indian people receive a substantially smaller portion of services than tribal-based American Indians.

MHD statistics show, in relation to parity, that American Indians in the State of Washington receive more state services than any other ethnic group overall; according to MHD data for the years 1993 and 1995, American Indians received twice as many services in proportion to the total State population as their population warrants.[34] However, this claim can be misleading, since MHD's parity figures for the years 1993 and 1995 are based on 1990 census data, which MHD used to calculate the population of American Indians in Washington State to be 76,397.[35] DOH (1997), on the other hand, estimated the total number of American Indians living in Washington State in 1990 to be 81,483. Furthermore, "[b]etween 1991 and 1995 they [American Indian population] grew an estimated 19.5%, from 89,453 to 106,919. In that same time period the state population grew by 8.6%. The American Indian population is forecasted to increase another 22% by the year 2005, up to 130,400. In contrast, the state's population is forecasted to grow by 16% between 1995-2005" (DOH, 1997:89).

Given DOH's findings, MHD's parity figures in relation to American Indians for the years 1993 and 1995 seems misleading. It is unclear how much MHD's parity figures (in relation to American Indians) would decrease by utilizing more accurate baseline population figures. However, even using MHD data, Gregory (1991) estimated that, for the fiscal year 1990, the average amount of MHD dollars spent on American Indians per capita to be $0.68, compared to $1.01 for Anglos, $1.04 for African-Americans, $0.97 for Asian-Americans, and $0.69 for Hispanics. These

[34] Parity is reached when a group receives services according to its percentage in the population. MHD contracts for a parity level of 1.0 or greater for ethnic minorities. (Less than 1.0 indicates the proportion of consumers served is less than their proportion of the state population). In 1993, American Indian clients received a service ratio of 2.25 (1.25 over parity), based on a population of 76,397 (1990 census data). In 1995, clients received a service ratio of 2.17 (1.17 over parity), also based on a population of 76,397 (1990 census data).

[35] The U.S. Census Bureau estimates that it undercounted American Indians under the age of 18 in Washington State by 6.7% in the 1990 Decennial Census, and 5.1% of American Indians overall.

findings contradict MHD's claims that they are over serving American Indians, in relation to other ethnic groups.

Gregory (1991) also commented in her paper that MHD uses misleading methodologies to compute their outpatient service delivery figures, with relation to American Indians. She presented the case example of the King County RSN, an agency which provides limited contract funds to the SIHB (an American Indian mental health program that operates almost totally on federal and third-party funds). The RSN then collects patient treatment statistics from the SIHB which the RSN uses as evidence that it has served a number of American Indian clients; the only problem with this reporting practice is that a portion of the costs of the service provided to each client for which the King County RSN takes credit, are paid for with IHS funds.[36] In addition, Gregory (1991) noted that:

> ... computations, based upon total Indian patients, divided by the number of counties in the state, are highly misleading. They indicate, falsely in this writer's view, that American Indians constitute a disproportionately high component of local mental health outpatient programs ... King County shows outpatient treatment to 432 Indians, and is averaged with Adams County (0 Indians) and Columbia County (1 Indian treated), etc. across the state. The figures emerging from this computation process appear misleading (Gregory, 1991:6).

Conclusion

The concept of American Indian mental health programs (or for that matter, any mental health program) maintaining statistical data as an attempt to better understand the general state of mental health among its American Indian clientele raises a number of complicated issues. For tribes, maintaining extensive written and statistical information that describes the mental health status of their communities is not culturally congruent with traditional American Indian beliefs. Furthermore, mental illnesses in American Indian communities are commonly viewed as being interrelated with the physical body, spirituality, and the physical environment, and are therefore not easily quantified. If statistical data is kept as a means to describe the mental health status of American Indians in Washington State, it must be kept tribal-specific (and tribal-based data must be kept separate from urban-based data), because every American Indian community is unique, and one cannot accurately gage the mental health status of one tribe by utilizing data that describes another tribe. Finally, if statistical data describing an American Indian tribe is maintained, it is imperative that the tribe retain control over the information.

[36] Steenhout (1996) found that a number of tribal-based American Indian mental health programs felt that other RSNs in the Washington State used similar data reporting processes.

American Indians in Washington State receive mental health services from several different locations (IHS run facilities, tribal run programs, urban-based programs, and RSN contracted providers). These different programs have no formally established link with one another. As a result, what limited data is available is fragmented. These issues impede the creation of a reliable set, or source, of data from which one can confidently measure the general state of mental health of American Indians in Washington State. Presently, tribes in the State of Washington seem willing to participate in statewide data collection efforts, as long as this process is not too burdensome on staff and is designed by tribes, for tribes, and the resulting data controlled by tribes or an Indian organization.

Similar to national trends, American Indians in Washington State suffer from considerably high rates of mental health problems such as depression, substance abuse, and destructive acting-out type behavior (such as suicide, fighting, and acting recklessly), as well as several other types of mental illnesses, some of which are not formally recognized by Western science; the extent of mental health problems in American Indian populations is especially clear when prevalence data is compared with that of other ethnic groups. American Indian children appear most at risk, with shocking rates of SED, suicide, and substance abuse. Tribal-based programs in the State of Washington estimate rates of co-occurring disorders among their service population at between 70 to 90 percent. Although the need for mental health services for American Indian populations in Washington State is apparent and great, it seems clear that the State of Washington is far from meeting these compelling service needs. With the ability to bill Medicaid under the MOA, tribes are now able to provide a better range of outpatient services, although the inpatient system continues to inaccessible to tribes.

Chapter Five: State-Tribal Relations in Washington State

In the State of Washington, relations between Indian-non-Indian governments are often poor. To a certain degree, these poor relationships are a product of the disputes that naturally arise when different governmental entities have overlapping or contiguous jurisdictions. In regard to state and local governmental agencies responsible for delivering publicly funded mental health services, these relations are further strained by the inherent demands of accommodating the needs of an ethnic minority population. However, these intergovernmental relations are also poor for less typical reasons, such as the history of colonial oppression under which tribes have had to exist, and the disputed position tribal governments currently hold in relation to the United States' federal governmental system.

In this chapter we explore the current state of relations between Indian-non-Indian governments in Washington State, discuss some of the factors that contribute to the problems found in these relations, and provide a model for increased cooperation between these governments. Though much of the discussion occurs within the broader context of intergovernmental relations in general, the focus is on relations involving mental health issues in particular. The chapter is divided into three primary sections. In the first section we discuss the history of Indian-non-Indian relations in Washington State. In the second section we explore some of the underlying reasons for the dysfunctional state of Indian-non-Indian relations in Washington State (giving particular attention to this issue within the context of the State's mental health delivery system). In the third section we conclude the chapter by presenting a model for increased cooperation between tribal, and state and local governments.

The History of State-Tribal Relations

In order to understand the current state of relations between tribal, and state and local governments in Washington, one must understand the historical backdrop against which these relationships developed. The history of Indian-non-Indian relations in Washington State, like broader American history, has been marked by a clash of cultures and competing claims for land and resources. Subsequently, conflict has been a constant aspect of this history, and is still very much a part of Indian-non-Indian relations in Washington State.

Early History

Prior to the arrival of Europeans in the area, the social organization of Washington's indigenous population was not characterized by discrete self-governing tribes (Dale, 1969; Deloria, 1977; Ross, 1967; State of Washington, 1977).

Though distinct ethnic and linguistic groups were present, both the political organization and the leadership of American Indians in this area were decentralized and often very loosely structured (Dale, 1969; Deloria, 1977; Ross, 1967). The main units of social organization were, in fact, small independent villages (often comprised of a single extended family) that maintained ties to other villages through intermarriage, trade, and cultural similarities (Dale, 1969; Deloria, 1977; Ross, 1967; White, 1991). "Though a leader ... might be accepted for several settlements, his authority was limited to providing counsel and leadership; he could speak only for his own followers and could give no orders" (Dale, 1969:6).[37] Leadership was often a matter of a group showing deference to an individual who was the acknowledged authority in a particular task (Ross,1967).

The State of Washington's indigenous groups subsisted primarily through hunting, gathering, and fishing (with fishing being of particular importance) (Dale, 1969; Deloria, 1977; Ross, 1967; State of Washington, 1977).

> With slight exception, fish, particularly salmon, played an important role in the Indians' diet and culture. This reliance on fish was more true for the Indians residing in what is now western Washington. However, Indians on both sides of the Cascades were adept at drying and preserving salmon which was generally a staple in their diets (State of Washington, 1977:3).

Far from just subsisting however, these indigenous groups had developed an extensive trading network, that often extended from east of the Cascades to the Pacific coast (Deloria, 1977). For instance,

> The western Indians sold slaves (people they had captured in war), haikwa (a precious sea shell), dried clams, and camas roots to the tribes in the mountains and farther inland in exchange for mountain-sheep wool, porcupine quills, embroidery, and particularly for a certain kind of grass from which they made delicate threads for sewing. The peoples who lived on the western slopes of the Cascades brought mountain-goat meat to the Makahs and traded it for whale meat and oil. The Makahs, in turn, traded the meat for red ochre, used for paint and cosmetics, and found only in Quileute territory (Deloria, 1977:15).

As in other parts of the New World, the entrance of Europeans into the area began a contest between the colonial powers to assert exclusive control over the region. By 1846, the United States had reached an agreement with England that granted the U.S. sole jurisdiction to the Oregon Territory below the 49th parallel. In 1850, Congress passed the Oregon Donation Act, which allowed settlers to claim up to 320

[37] Some American Indian groups east of the Cascades, due both to the introduction of the horse and the influence of Plains Indian cultures, displayed a more highly organized "tribal" social system (Dale, 1969; Ross, 1967), the Nez Perce being the most notable example (Dale, 1969).

acres of public land in the territory. Significantly, this act encouraged settlement on land not yet acquired from its American Indian owners.

In March of 1853, Washington became a separate territory of the United States, and Isaac Ingalls Stevens was appointed its governor. Stevens was directed to secure treaties with the American Indian tribes of the territory in order to extinguish their title to the land, thereby rectifying the problems that the Oregon Donation Act had created. By mid-1855, Stevens had negotiated six treaties that form the basis for most American Indian reservations in Washington State today.[38,39] These treaties are:

- The *Treaty of Medicine Creek*, with the Nisqually, Puyallup, Squaxin and other tribes or bands.
- The *Treaty of Point Elliott*, with the Duwamish, Suquamish and other tribes or bands.
- The *Treaty of Point-no-Point*, with the S'Klallam, Skokomish and other tribes or bands.
- The *Treaty of Neah Bay*, with the Makah.
- The *Treaty of Camp Stevens*, with the Yakama and other tribes or bands.
- The *Quinault and Quileute Treaty*, with the Quinault and Quileute.

With minor exceptions, these treaties are all similar. The more important provisions of each treaty were: the relinquishment of most of the tribes' lands; the creation of a reservation to be occupied by the tribes within a year of the treaty's ratification; the payment of annuities by the federal government; the establishment of the U.S.'s prerogative to divide the reservation land in severalty;[40] aid for the tribes in the form of buildings, mills, farmers, teachers and physicians; and the reservation of fishing rights by the tribes.

The treaty negotiations with these tribes were problematic in a number of ways. To begin with, as was discussed above, "...there were no 'tribes' for the United States to negotiate with. To expedite negotiations, the United States had simply created tribes and then arbitrarily appointed chiefs to do the negotiating" (White, 1991:93). Furthermore, Stevens insisted that the negotiations be conducted in Chinook, a trade jargon that consisted of only about 300 words taken from French, English, and a number of American Indian languages (Deloria, 1977; State of Washington, 1977; White, 1991). Owen Bush, one of Stevens' staff, would later complain: "I could talk the Indian languages, but Stevens did not seem to want anyone to

[38] A few American Indian reservations in Washington State were created through executive order or acts of Congress (State of Washington, 1977).

[39] A number of tribes in Washington State remain either landless, unrecognized by the federal government, or both. This can occur when the tribe, though a signatory to a treaty, was never allocated its reservation, or if the tribe was targeted for allotment on another reservation, but never received their lands and subsequently returned to their traditional area (GOIA, 1991).

[40] The division of land in severalty means the apportionment of parcels of land to individual owners.

interpret in their own tongue, and had that done in Chinook. Of course it was utterly impossible to explain the treaties to them in Chinook" (Deloria, 1977: 58; State of Washington, 1977:5).

The treaties themselves were problematic as well. According to the State of Washington (1977):

> [T]he treaties were clearly unfair to the Indians involved. For example, the initial Nisqually reservation worked out to four acres per individual and the acreage was an upland wilderness area unsuitable for cultivation. Other reservations lumped tribes together which had been traditional enemies and placed Indians in reservations far from their traditional areas (State of Washington, 1977:6).

Stevens would ignite American Indian anger over these treaties when, in June of 1855, he and Joel Palmer (Oregon's Superintendent of Indian Affairs) signed an announcement that proclaimed the opening of the ceded lands to settlement, and then printed it in various Oregon and Washington newspapers (Dale, 1969; Deloria, 1977; Ross, 1967). This advertising was done prior to ratification of the treaties by Congress, contrary to both instructions from Washington, D.C., and the provisions of the treaties themselves (Dale, 1969, Deloria, 1977). Settlers immediately began invading American Indian lands east of the Cascades, which promptly resulted in the eruption of the "Yakima War" of 1855 (Dale, 1969; Deloria, 1977; Ross, 1967; White, 1991). West of the Cascades, as a result of their displeasure with the treaties, the Nisqually and their allies joined in the hostilities as well (Dale, 1969; Deloria, 1977).

In the end, American Indian groups lacked the solidarity necessary to carry out a successful campaign against the European Americans in the area, the American Indian effort soon collapsed (Deloria, 1977). Nonetheless, for some tribes, the long term results of the Yakima War "...were new reservations more in line with the instructions under which Governor Stevens was supposed to have operated in his treaty negotiations" (State of Washington, 1977:6). However, by the turn of the century, the State and tribes would again be in conflict, though (as is discussed below) this conflict would be played out in the legal, rather than not military arena.

State-Tribal Conflict

While Washington remained a territory, the rights secured by tribes in the treaties described above, were respected. As a territory, "[t]he governor and the judges were both appointed by the President, and ... all officials had to carry out the federal laws of the United States, and among these laws were the treaties signed by Isaac Stevens with the tribes ... There was no intervening government to pass contradictory laws affecting treaty rights, and in this sense the territorial status of Washington served to protect the Indians ..." (Deloria, 1977:101). This would

change when Washington received statehood in 1889 (Deloria, 1977; Storm, et al., 1991). As Pevar (1992) notes:

> States and tribes are not the best of friends. States resent the fact that reservation Indians are not normally subject to state taxation and regulation, and Indians resent the states' constant attempts to tax and regulate them. The state-Indian conflict has been a long and bitter one. More than a century ago the Supreme Court noted that there was so much local ill-feeling against Indians that "the people of the states where they are found are often their deadliest enemies" (Pevar, 1992:111).

The most conspicuous conflict that would arise between Washington State and the American Indian tribes within its borders would begin developing soon after statehood was achieved (Deloria, 1977; Storm, et al., 1991). As explained above, fish, especially salmon, was of enormous economic and cultural significance to the indigenous groups that resided in what is now Washington State. As a result of this, the six treaties listed above contained provisions implying that the American Indian groups who signed those treaties would remain unhindered in their fishing activities at their traditional sites. However, "[b]y 1900, Indian attempts to exercise treaty [fishing] rights began to meet with increased resistance as the number of non-Indian fisherman grew and the numbers of fish began to decline sharply" (Storm, et al., 1991:286). A pattern soon developed in which Washington State, supported by non-Indian commercial- and sport-fishermen, would attempt to regulate the fishing activities of these "treaty Indians." As a result, these tribes argued that the treaties had insured their retention of the right to fish without interference from the State, while the State argued that the treaties did no such thing (Deloria, 1977; Storm, et al., 1991).

This conflict was heated, and at times even violent (Deloria, 1977). It culminated in the 1974 federal district court case *United States v. Washington*, and the 1979 Supreme Court case *Washington v. Fishing Vessels Ass'n*. In both of these cases, the court sided unequivocally with the tribes (*United States v. Washington*, 384 F. Supp. 312; *Washington v. Fishing Vessels Ass'n*, 443 U.S. 658). Despite these decisions, the controversy and litigation continues (Storm, et al., 1991).

Another area of conflict includes the extent to which Washington State has criminal, civil and regulatory jurisdiction within tribal reservations (GOIA, 1991; Pevar, 1992; Ryser, 1992; State of Washington, 1977). Most American Indian tribes view themselves as sovereign nations, holding equal status to the federal government. As such, they regard states as having no legitimate governing powers within Indian country. However, like other states, Washington has continually attempted to assert control over matters occurring within Indian country (GOIA, 1991; National Conference of State Legislatures, 1995; Ryser, 1992; State of Washington, 1977).

This conflict has become particularly intense since the 1960s, when the federal government shifted its Indian policy toward the support of tribal self-government. As tribal governments began divesting themselves of BIA control and asserting authority over their own communities, non-Indians who had acquired land within reservations (primarily through the Dawes Act) began objecting "... to the growing exercise of general governmental powers by tribal governments. This was particularly true in the areas of taxation, zoning, construction and land-use ordinances" (Ryser, 1992:10).[41] Upset because they are increasingly subject to governments in which they are not allowed to participate, non-Indian reservation landowners have collaborated over time with Washington State officials in attempts to diminish tribal governmental authority within reservations (Ryser, 1992).

Despite all of this, Indian-non-Indian relations have improved considerably in Washington State in recent decades. The State of Washington has increasingly acknowledged the unique legal status of American Indian tribes, and has taken steps to honor their request to be dealt with on a government-to-government basis. For example, in 1983, Governor John Spellman issued Executive Order 83-16, which affirmed the State's goal of supporting a government-to-government relationship with tribes. Furthermore, in 1980, the State established the Governor's Office of Indian Affairs (GOIA) to administer Washington State's relationship to Indian country; this office is mandated to: assist the Governor in the development of policies that pertain to tribal governments and Indian organizations; assist American Indians in their efforts to work with state government in solving mutual problems; and advise state agencies and departments concerning issues relative to the Indian tribes and organizations in Washington State.

Another example is the 1989 Centennial Accord, signed by Governor Booth Gardener and Washington State tribes. This agreement re-affirmed the State's continuing commitment to the establishment of a more developed government-to-government relationship with tribes, and serves as the cornerstone of relations between tribes and the State of Washington today. "With the Centennial Accord as a foundation, [the State of Washington] and tribes have made progress in working together as intergovernmental partners in the provision of services and regulatory matters" (DOH, 1997:29).

Nonetheless, State-tribal relations remain problematic. Nationally, "[m]any tribal leaders note that although their states have formally recognized tribal sovereignty, that status is neither acknowledged nor understood by many state officials" (National Conference of State Legislatures, 1995:9). This sentiment is expressed by numerous tribal leaders in Washington as well.

[41] By the 1980s, more than 500,000 non-Indians claimed land on Indian reservations nation-wide (Ryser, 1992).

Relations are particularly strained between tribes and local Washington State governments. For instance, addressing the field of public health, the Washington State Department of Health has noted:

> In some areas of Washington, tribes have developed good relations with local administrators or regional agencies. However, in many cases, there is distrust and misunderstanding between tribes and local governments due to lack of information, misunderstanding sovereignty, different interpretations of federal responsibility, shifting governmental policy, and limited resources. Even when program administrators fully support working with Indian health programs, often the alliance between the program's governing board and the tribal leaders is nearly non-existent because of long standing conflicts (DOH, 1997:19).

Though this statement only addresses the state of relations between tribes and local governments within the context of public health, it is indicative of the State-tribal relations in general.

Sources of Intergovernmental Conflict and the Current State of Relations Between American Indian Mental Health Programs and the RSNs

As was addressed in the previous section, relations between Indian-non-Indian governments are often strained due to conflicts over jurisdictional issues. To a certain degree, such conflicts are natural between governmental entities that share overlapping or contiguous jurisdictions. However, conflict between Indian-non-Indian governments is particularly heated because of the disputed position tribes hold in relation to the United States federal system. Within the context of mental health, intergovernmental conflict continues because of the inability of Washington State's mental health system to provide American Indians adequate access to culturally competent mental health services, given the cultural, geographic, and systemic barriers involved. In this section, we explore both the current state of relations between American Indian mental health programs and the RSNs in Washington State, and some of the reasons why these relations are generally poor.

Legal Status of Tribes

Though conflict is natural between governmental entities that share overlapping or contiguous jurisdictions, conflict between Indian-non-Indian governments is particularly intense because of the disputed position tribes hold in the United States federal governmental system. This system was designed to contain only three primary parts: federal, state and local (county and municipal) governments. However, as was explained in Chapter Three, the federal government has recast tribes from sovereign nations that exist outside the U.S. federal system, to quasi-sovereign governmental entities that exist within it. Since this transformation has

occurred unsystematically over time, has occurred without tribal consent, and has resulted in tribal governments holding a position that lacks a constitutional foundation, there is a substantial degree of controversy over the respective jurisdictions of tribal, state and local governments in regard to Indian country and tribal members. Furthermore, because new federal laws (either Congressional or judicial) routinely alter the legal status of tribes within the U.S.'s federal system, this controversy defies resolution.

In Washington State, as elsewhere in the United States, the disputed legal status of tribal lands, members, and governments has resulted in heated and continual jurisdictional disputes as state governments have endeavored to increase their control over both Indian country and tribal members. State governments have attempted to retain control, in part, because to the degree that tribes remain legally autonomous enclaves within state boundaries, the efficacy of generally applicable state laws is threatened (Center for World Indigenous Studies, 1986; GOIA, 1991). For example, such autonomy could undermine the ability of state environmental regulations to achieve their intended effect. Another reason for these efforts by state governments is that they often resent the fact that they are expected to provide services to tribal members, yet are significantly hindered in the application of their tax laws within Indian country (GOIA, 1991). A third reason is that the general exclusion of non-Indian reservation property owners from participation in tribal governments, as well as the unique legal rights of American Indians, are deeply troubling to many non-Indians, who find these things contradictory to America's democratic and egalitarian ideals (National Conference of State Legislatures, 1995; Ryser, 1992).

For their part, tribes have continually fought against the assertion of state governmental control over Indian country, as well as any attempt by state governments to limit the rights tribes reserved by tribes through treaties with the United States. Tribes often argue that they never consented to having their sovereignty limited by the U.S., and tribes therefore remain outside of the federal system as nations equal in sovereignty to the United States and other countries. As a result, any assertion of state jurisdiction over Indian country is deeply troubling to most tribes, representing the ongoing attack on their sovereignty by a colonial power. Tribes point out that they in essence signed away most of what is now the United States in order to retain their cultural and political autonomy, and greatly resent efforts by state governments to further restrict tribal sovereignty on the limited amount of land they have managed to retain. Many American Indians feel that such attempts by state governments result from a flawed understanding of the unique legal status of tribes, as well as an ignorance of the historical context under which this legal status developed.

Conflict Between Tribes, RSNs, and MHD

Jurisdictional disputes are generally the main source of controversy between Indian-non-Indian governments; however, within the context of mental health, other issues inspire contention as well. One such issue involves the ability of Washington State's mental health system to provide American Indians adequate access to culturally competent mental health services, given the cultural, geographic and systemic barriers involved. A second issue involves the fact that the RSN system is operated at the local level, where the meaning of tribal sovereignty mat not be understood or simply ignored; in addition these local governments may not understand or respect the meaning of the Centennial Accord agreement, which provides them with a framework for interacting with tribes on a government-to-government basis.[42]

Steenhout (1996) interviewed the ten RSNs with tribal communities in their regions and all 24 American Indian mental health programs in the State of Washington, concerning the current state of intergovernmental relations. It was found that:

- Relations between tribes and RSNs varied significantly by region.
- In general, most RSNs and tribes reported problems in past or current negotiations.
- Eight of the ten RSNs commented that relations with the tribe(s) in their respective regions were either moderate (four cases), bad (one case), or that they had no relationship at all with one or more of the tribes in their region (three cases).
- Twenty of the American Indian mental health programs commented that relations with the RSN were either moderate (four cases), bad (six cases), poor (three cases), or that they had no relationship at all with the RSN (seven cases).

Steenhout (1996) linked the general state of poor relations that existed between some RSNs and tribes (or the lack of relations altogether) to communication breakdowns during negotiations, the failure of some RSNs to deal with tribes on a government-to-government level in negotiations and relations, and the failure of some RSNs to contract with culturally competent providers. Steenhout (1996) also discovered that many RSNs felt that they had made considerable efforts to meet the service needs of tribal communities, and felt tribes failed to acknowledge these efforts.

In an attempt to update the research Steenhout (1996) conducted, Steenhout & St. Charles (1997) interviewed many of the administrators and providers employed by Washington State's 24 American Indian mental health programs, 10 RSNs with tribal communities in their regions, and CMS, IHS, MHD, MAA, IPSS, and officials

[42] Local governments are not bound by the Centennial Accord (since it is an executive order, not a law).

in other governmental agencies who interact with American Indian mental health professionals. Compared to findings of Steenhout (1996), Steenhout & St. Charles (1997) discovered that:

- Several RSNs seemed more knowledgeable of the unique legal status that tribal communities hold as sovereign nations.
- Some RSNs and American Indian mental health programs feel that the current state of relations between them were slightly better (than in the summer of 1996, when research for Steenhout (1996) was performed).
- Though still only three RSNs have tribal governmental representation on their governing board, another RSN claims that it is close to reaching an agreement with several tribes that will result in tribal representation on its governing board.
- Some state and local government officials commented that they had trouble negotiating with tribes, because the tribes sometimes treated them disrespectfully, or blamed them for things that were out of the agency's control.
- Another complaint that state and local government officials communicated (concerning their relations with representatives of American Indian mental health programs) was that tribal representatives were not always clear and timely with their concerns and complaints. Furthermore, when new tribal representatives became involved in an ongoing negotiating process, they sometimes seemed overly aggressive, either slowing down or halting the process altogether.
- On their part, tribal representatives often felt that the RSN would not negotiate in good faith (this usually concerned tribal representation on the RSN's governing board) and did not respect the sovereign status of the tribe.
- Some tribal representatives noted that during past negotiations, state governmental officials made commitments or promises that they did not follow through with. Both state officials and representatives of American Indian mental health programs regularly asserted that the opposing entity did not fully understand or respect the other position in most disputed matters.

In 2001, we once again addressed the issue of the current relations between tribes and RSNs, finding that relations had improved some among these governments. In general, RSNs described the state of their relationships as being better than 1997, a position that most tribes took also. However, when asked to rate the current relationship as excellent, good, neutral, poor, or terrible, most RSNs chose "good to excellent", while Tribes tended to choose "poor, neutral, or good."

Based on our research, improvements have been made by RSNs to understand and respect that tribes are sovereign nations existing within their boundaries, and are

fundamentally different than other minority groups. Additionally, more RSNs are contracting with tribes to support their programs, requiring that contractors make efforts to provide culturally competent services to American Indians, having more formal agreements with tribes in place relating to ITA jurisdiction issues, and allowing more participation on their governing boards by tribes. Much of this improvement can be attributed to the increased 7.01 planning and policy development within the RSNs.

Most representatives of both American Indian mental health programs and RSNs commented that they dealt with conflict when it arose through face-to-face negotiation. In some cases, if resolution over an issue could not be achieved, MHD's tribal liaison was asked to join the negotiation process. Significantly, most tribes do not currently have a formal written agreement between their mental health program and the RSN (or the RSN's Crisis Response Team(s)), that define the roles and responsibilities of each entity in relation to the other (as well as the protocols each should employ in its interactions with the other). Such an agreement would not only facilitate negotiations by clarifying the relationship of these governmental entities, it would reduce the conflicts.

Model for Improved Relations

As has been explained, though the state of relations between Indian-non-Indian governments in Washington State has improved in recent years, they remain generally poor. In this section we present suggestions for improving these intergovernmental relations. We also present a model that can be employed by tribal, federal, state and local government employees to facilitate, on a personal level, their interactions with one another during intergovernmental negotiations.

Collaboration and Mutual Respect

Though negotiation and dialogue are the primary tools for resolving Indian-non-Indian conflicts, conflicts often fail to be resolved through this process. The method traditionally employed by these governments to deal with a failure to resolve disputes has been litigation. However, there are a number of reasons for tribal and state governments to limit this pervasive practice and work out their differences in a more collaborative manner. One reason is simply the cost involved in such extensive litigation. Another is that it rarely solves the problem.

> To a large extent, the litigation in the tribal-state relationship has become a game in which each side pursues a case which seems favorable to its cause. When the case has been finally decided, the losing side rarely applies the principles of that case to analogous situations in its own relationship. Instead, it characteristically looks for an analogous case with a slightly different set of facts in the hope that the new case will:

- bring about a reversal of the previous decision;
- suggest a principle which severely narrows the application of the principles of the previous decision; or
- offer a principle which conflicts with the previous decision in such a way that a new areas of ambiguity - and therefore maneuverability - can be established (Commission on State-Tribal Relations, undated).

For state and local government governments, other reasons include the "... increased willingness by the U.S. Congress to delegate to Indian tribes regulatory and implementation functions previously accorded only to states," and the fact that tribes are increasingly winning these court cases (Center for World Indigenous Studies, 1986; National Conference of State Legislatures, 1995:19).

Though it is unreasonable to expect tribal, and state and local governments to resolve all disputes without the courts, these governments should nonetheless attempt to coordinate their policies and practices in areas of exclusive jurisdiction and cooperate to assure adequate governmental service where jurisdiction remains disputed. The first step in achieving such intergovernmental collaboration is recognition by state and local governments of tribal sovereignty. If these governments are unwilling to accept tribes as sovereign nations that exist outside of the United State's federal system, they should at least acknowledge tribal governmental autonomy as it exists within this federal system. State and local governments should further recognize that under this system, state governments have, with rare exceptions, no jurisdiction within Indian country except to the extent that federal legislation has made specific exceptions.

Concurrent with this recognition of tribal sovereignty, state and local governments should deal with tribes on a government-to-government basis. "In a government-to-government relationship, both a state and a tribe recognize the right of the other entity to protect the health, safety, and welfare of its citizens" (National Conference of State Legislatures, 1995:72). Within this government-to-government relationship, state governments should recognize the importance of protocol. "The use of proper channels demonstrates mutual respect and lends dignity to relationships that are often delicate and easily tainted by misunderstanding and the suspicion that state (or federal) bureaucrats are attempting to interfere with internal disputes of tribal governmental officials" (National Conference of State Legislatures, 1995:75). State governments should work collaboratively with each tribal council to define these protocols.

For their part, tribes should make efforts toward understanding state and local governments, their motivations, and the constraints under which they operate. Tribes often attribute all of their coordination problems with state governments to anti-Indian, anti-tribal-government policies (Commission on State Tribal Relations, undated). "[Tribes] fail to realize that at least some of the problems arise from the inevitable intergovernmental friction which always occurs between neighboring or

overlapping jurisdictions. A state may have exactly the same problem with neighboring states or with the federal government, but the tribe often fails to realize this and is therefore unable to suggest ways of managing the conflicts" (Commission on State Tribal Relations, undated). Tribal officials also often fail to recognize that many of the difficulties they encounter in dealing with state governmental officials arise out of the myriad of mandates, restrictions and time constraints under which these officials operate. In addition, tribal concerns are one of the many competing issues that crowd the desks of these state officials (National Conference of State Legislatures, 1995).

A Model for Improved Negotiations

While doing research for this document, we decided to augment the suggestions for intergovernmental cooperation listed above with a model that could be used by tribal, state and local governmental officials to guide them (on an individual level) in negotiations, with other governmental agencies. We arrived at this decision for two reasons. First, we discovered in preliminary research that many state governmental officials want positive interaction with tribes, but are uncertain of how to actually approach and interact with tribal representatives. Second, we could find only one Indian-non-Indian relations manual created by Washington State for its employees (a GOIA training manual), and in reviewing it we were struck by the fact that it provides only a general historical perspective of Indian-non-Indian relations, and little guidance is given as to how an individual should approach intergovernmental relations.

The following model is designed for representatives of tribes and state governments to consider prior to and during, interactions with one another. It was created with what we learned from the many professionals we interviewed about intergovernmental interaction and relations.

Step One: Prior to First Contact

- Employees of state and local governments (henceforth referred to as non-Indian government employees) must respect the autonomy of tribal communities; this respect includes having at least a rudimentary understanding of the meaning of tribal sovereignty (information on this subject can be obtained from GOIA, IPSS, or from the tribal community with which the state employee is planning to interact).
- Non-Indian government employees must be willing to interact with tribes on a government-to-government basis (based on a framework similar to the one described by the Centennial Accord Agreement of 1989).
- Tribal governmental representatives (henceforth referred to as tribal representatives) should interact with the state government without

holding it or its employees accountable for past conflicts that the tribe has had with other state governments.

- Tribes, and state and local governments should be willing to take turns hosting and traveling to the meetings. There should also be cost sharing between these governments.

Step Two: Preliminary Interactions

- Non-Indian government employees should realize that when interacting with tribal representatives, they are doing so in a cross-cultural environment. American Indian and non-Indian people have many cultural and value differences, and tend to use different methods of social interaction and interpersonal communication. Indian and non-Indian professionals should understand, and respect, these differences in order to improve the success of the communication process.
- Non-Indian government employees should recognize that, due to the troubling history of relations between tribal, and state and local governments, tribal representatives have a tendency to distrust the representatives of outside governments. Building trust between non-Indian government employees and tribal representatives may take considerable time.
- The first meeting between tribal representatives and non-Indian government employees should be informal and free of a rigid agenda. The meeting should emphasize learning about one another and discussing how to model future interaction.

Step Three: Initiating a Collaborative Process

- In the first formal meeting, collaboratively lay out and prioritize the issues (agenda) for discussion.
- Discuss and set a time frame to address each of the issues which both parties are comfortable working.
- Decide together which issues will be discussed in a meeting, and address those issues in order. If all the issues on the agenda cannot be discussed in one meeting, set another meeting for a mutually acceptable time.
- At the end of each meeting, allow a time period for each person to speak (especially those who have been quiet during the meeting). Make an added effort to listen and not dominate the conversation. Aside from being a matter of courtesy, this is important because American Indian people can be more restrained than non-Indians in regard to verbal participation during meetings.

Step Four: Revisiting Past Decisions and Ensuring Action

- At the beginning of each additional meeting on the same agenda, revisit the agreements that were made in prior meetings. Make sure that each party is still comfortable with the past agreements.
- Once a meeting(s) on a particular agenda has concluded and an agreement has been reached between the parties, the tribal government, and state and local governments may wish to produce a formal written memorandum of understanding to finalize the agreement. The State Interlocal Cooperation Act (RCW 39.34) can be used as a means for tribes and state governments to establish these formal agreements.
- It is important that tribal government, and state and local governments follow through with their commitments to one another. They should also maintain communication after meetings have concluded and while the actual policy change occurs. Ongoing communication is important because, in some cases, even though tribal and non-Indian government representatives reach an agreement on an issue, forces beyond the control of both parties may prevent the policy agreement from being implemented. For example, if representatives of an American Indian mental health program and an RSN reach an agreement on an issue, but the RSN governing board or tribal council intercedes to prevent the policy change from occurring, the party affected should contact the other to explain what happened.

Conclusion

Though there has been improvement in recent years, relations between Indian-non-Indian governments in Washington State remain poor, with relations between tribes and local governments being especially so. Though these poor relations are partially a product of natural jurisdictional conflicts, these conflicts are aggravated by the disputed legal status tribes hold in relation to the U.S. federal governmental system. Also contributing to this poor state of relations is the distrust of outside governments that the history of colonial oppression has engendered in American Indian communities.

In regard to relations between tribes and the State of Washington involving publicly funded mental health issues, there are two further sources of controversy. The first involves the ability of Washington State's mental health system to provide American Indians adequate access to culturally competent mental health services given the geographic, cultural and systemic barriers involved. The second source of controversy arises from the fact that the RSN system is operated at the local level, where in many cases the meaning of tribal sovereignty is not well understood, or in some cases ignored.

Based on recent interviews, it seems relations between RSNs and tribes have improved since 1997. This is due largely to a greater respect for and understanding of tribal sovereignty among RSNs. Additionally, more RSNs are contracting with tribes to support their programs, requiring that their contractors make efforts to provide culturally competent services to American Indians, having more formal agreements with tribes in place relating to ITA jurisdiction issues, and allowing more participation on their governing boards by tribes. Much of this improvement can be attributed to the increased 7.01 planning and policy development within the RSNs.

For both tribal and non-Indian governments there are benefits for improving their relations with each other. As such, we have presented suggestions for increasing collaboration and cooperation between these governments. Furthermore, because of the difficulties that often arise when tribal, and state and local government officials interact with one another, we have also presented a model with which to facilitate negotiations between these professionals.

Chapter Six: Mental Health Care Systems and Levels of Access

As has been discussed, most American Indian communities are currently faced with pressing mental health needs. In this chapter we explore the two parallel, publicly funded mental health systems that American Indians in Washington State can access to meet these needs (the IHS and State systems). We also discuss the necessity of cultural competency in the delivery of mental health services to American Indian people, and explain the differences between these two systems in regard to such cultural competency. In addition, we discuss the funding mechanisms that support Washington State's mental health system as a whole, the need for American Indian mental health programs to be able to access this funding, and issues surrounding the delivery of crisis response and ITA services to tribal communities by the RSNs.

This chapter has three sections. In the first section, we discuss the parallel systems that American Indians in Washington State can access to receive mental health services (the IHS and State systems). In the IHS system, tribes under a 638 contract operate most tribal-based mental health programs, commonly referred to as "look-alike, stand-alone, IHS 638 programs." The programs receive limited funding from IHS, largely depending on Medicaid billing, third-party insurance, and/or tribal enterprise revenue to operate. On rare occasions, IHS will run behavioral health programs directly on reservations, typically as a component of their health programs. In the State system, RSNs provide mental health services to eligible residents, including American Indians. RSNs are required by State law (and their contracts with MHD) to provide these services in a culturally competent fashion.

In the second section, we provide a summary of how the State of Washington's mental health care system is funded. We also discuss programs run within MHD that provide opportunities for tribes to access project funding and staff training.

In the third section, we discuss the systemic similarities and differences between American Indian and mainstream mental health programs, within the context of culturally competent service delivery. Cultural competence is the cornerstone of American Indian mental health programs. Though American Indian mental health programs deliver these culturally competent services, most RSNs do not (though RSNs are required by law to do so). We also discuss MHD's failure to ensure that these RSNs are working according to legal and contractual mandates in regard to culturally competent service delivery.

Parallel Mental Health Care Systems for American Indians in Washington State

In Washington State, twenty-two of the twenty-nine federally recognized tribes have mental health programs. These programs vary significantly in the range of mental health services provided; in most cases however, these programs deliver only a limited range of services. In addition to these tribal-based programs, Washington State has two urban-based American Indian mental health programs, the Seattle Indian Health Board (SIHB), and the N.A.T.I.V.E. Health Project[43] The SIHB serves a large clientele of American Indian people in Seattle, while the N.A.T.I.V.E. projects serves clients in the Spokane area; like tribal-based programs, these programs struggle to maintain adequate funding mechanisms and meet the extensive mental health needs of the populations that the programs serve.

In addition to these tribal- and urban-based programs, American Indians in the State of Washington are entitled to access (on an equal basis with other residents) to all publicly funded State and local mental health services. As the State's designated mental health authority, MHD has primary responsibility for the oversight of delivery of these services to eligible residents. However, since 1989, Washington State's RSN system has enabled counties (or groups of counties) to have formal control in the planning, development, and delivery of mental health services within their jurisdictions. In this section, we discuss these two parallel systems (the IHS and RSN systems) that American Indians can access to receive mental health services.

Contractual and Funding Relationships with IHS

Under Public Law 83-568, the Transfer Act of 1954, IHS has primary responsibility for providing federally supported health care services to American Indians (including mental health services).[44] "The Indian Health Service was established in 1955, when responsibility for the health care of Native Americans was transferred from the Department of the Interior to the Department of Health, Education, and Welfare (now the Department of Health and Human Services)" (Nelson, 1991:1049). IHS provides mental health services to American Indians through American Indian mental health programs.

These programs have four primary organizational structures, or scenarios, in which they deliver services to their clients. In the first scenario, IHS employees provide

[43] An urban-based program means a program currently operating under Title V of PL 94-437. It should be noted that some American Indian mental health care programs located in tribal communities consider themselves to be urban-based programs, although they contract under PL 93-638.

[44] Congress has declared that IHS is the "payer of last resort"; this means that in the case of billing, third-party (private) insurance is the primary source of payment, Medicaid has secondary responsibility, and if both of these are exhausted, IHS contract funds are to be used.

services directly to the tribal community (in some cases using facilities that are owned or leased by IHS, and that are located within the community). In the second and third scenarios, the tribes operate the programs (often in tribal-owned facilities, though sometimes in IHS owned or leased facilities). In the fourth scenario, IHS provides financial support to urban-based American Indian mental health programs.

In regard to the second and third scenarios, IHS offers these mental health programs a limited degree of funding with curbed administrative control, out of respect for tribal sovereignty. Two landmark pieces of federal legislation, the Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638) and the Indian Health Care Improvement Act of 1976 (Public Law 94-437), have made this possible. The legislation " ... provides Native American tribes with the opportunity to manage and operate their own health and mental health programs, usually by assuming responsibility for programs operated by IHS" (Nelson, et al., 1992:258).

Title I of PL 93-638 created mechanisms whereby tribes can, if they wish, contract with IHS to support tribal-based programs that provide a specific set of mandated services, which are monitored by IHS (commonly referred to as contracted tribal programs). Amended in 1988, Title III of PL 93-638 allows self-governance tribes to extend their control over tribal-based programs. Under this scenario, tribes access funds from IHS in block grant form, and have considerable control over how those funds are managed and utilized (commonly referred to as compacted tribal programs).

PL 94-437 expanded health and mental health services for American Indians in urban areas. Title V of PL 94-437 (as amended) established mechanisms for non-profit corporations to contract with IHS to provide mental health services to urban-based American Indians. Currently, the SIHB and the N.A.T.I.V.E Project provides services to American Indians under this scenario.

It should be noted that IHS's financial support of these programs (under all four scenarios) is very limited. Many people assume that IHS provides an extensive array of mental health services to American Indians; this assumption however is incorrect. IHS provided sporadic mental health services to American Indians from its establishment until 1965, "... when the Office of Mental Health was established at the Navajo reservation headquarters office in Window Rock, Arizona. This fledging national program was directed by a Public Health Service psychiatrist and funded at less than $500,000 per year" (Nelson, et al., 1992:258). Though IHS line item funding for tribal- and urban-based mental health programs has increased steadily to $ 45,018,000 nationwide for fiscal year 2001, this amount is negligible in that it represents less than 2 percent of IHS's total annual budget of $2,628,766,000.

As a result of this marginal funding, IHS's ability to provide direct and contracted mental health services is very limited. In 1992, IHS had only 216 mental health direct service staff personnel nationwide (Nelson, et al., 1992). "The 216 direct service staff included 25 psychiatrists, 39 doctoral-level psychologists, 19 psychiatric nurses, 45 social workers, 11 social work associates, 45 mental health technicians, and 44 members of other disciplines. Only 20 direct service staff were reported to have had adequate training in child or adolescent psychiatry" (Nelson, et al., 1992:259). The limited nature of these mental health services hits urban-based American Indians especially hard, since they receive considerably less direct and contracted services from IHS than tribal-based American Indians (Nelson, et al., 1992).

State Supported Services for American Indians

MHD is the designated mental health authority for Washington State and has primary responsibility for the delivery of state mental health services to all eligible residents, including American Indians (for most services, eligibility equates to Medicaid eligibility). Since 1989, these mental health services have been provided through the RSN system. The creation of the RSN system enabled individual counties (or groups of counties) to have formal control of the planning, development, and delivery of mental health services within their jurisdictions.

> RSNs are counties, or collections of counties, who are responsible for planning, administering and managing the local publicly funded community mental health system ... their responsibilities include 24-hour crisis services, involuntary inpatient treatment, outpatient services, community residential and other community support services.
>
> They are also the gate-keepers for community inpatient and state hospitals admissions and stays. There are currently 145 licensed community mental health agencies within the state who perform some or all of services above (MHD, 1996:5).

Prior to the RSN system, tribes were required, in most instances, to access outpatient mental health services for their communities from individual counties. The creation of the RSN system forced tribes to work with the RSNs in acquiring these services. Historically, American Indians had little or no access to culturally competent mental health services from Washington State's mental health system, and little changed with the creation of the RSN system. Since the establishment of the RSN system, representatives of some tribes, members of Indian organizations and tribal advocates have worked with MHD to address long-standing problems with the State mental health system. Documents authored by Dr. Dolores Gregory (1991) and SPIPA (Steenhout, 1996) have detailed these problems, which include, but are not limited to:

- The failure of many RSNs to conform fully to the legally mandated guidelines of the State's mental health system.
- The unequal access that American Indian mental health programs have to State mental health funding and technical assistance to improve program services.
- The inability of American Indian mental health programs to receive payment for Medicaid services provided to clients.
- The failure of most RSNs to contract with professionals who are culturally competent and able to meet the specialized service needs of American Indians.
- Many RSNs not understanding, and some RSNs simply ignoring, the sovereign status of tribes and the established government-to-government relationship that tribes have with the State of Washington.
- Some RSNs failing to negotiate collaboratively and in good faith with tribes on a government-to-government basis.
- The difficulty that many tribes have encountered in their attempts to gain representation on RSN governing boards.
- The lack of empirical data describing the current state of mental health of American Indians.

Our recent interviews indicate that some progress has been made in addressing the above-mentioned problems; the levels of progress however seem to vary significant by region. The following are our current findings:

- With few exceptions, RSNs still do not conform fully to the legally mandated guidelines of the State's mental health system.
- American Indian mental health programs still do not have adequate access to State mental health funding and technical assistance to improve program services.
- As the result of the MOA, tribal-based mental health programs can now receive reimbursement for services provided to Medicaid eligible clients in their outpatient programs. This process takes place outside of the State of Washington's mental health care system, except the billing, which takes place through MAA.[45]
- RSNs have made some improvements in attempting to contract with professionals who are culturally competent and able to meet the specialized service needs of American Indians.
- All RSNs seem to now understand the sovereign status of tribes and the established government-to-government relationship that tribes have with the State of Washington.
- Several RSNs are doing a better job negotiating collaboratively and in good faith with tribes on a government-to-government basis. This improvement can be accredited to improved 7.01 policy implementation.

[45] MHD and MAA have no authority to place any requirements on these programs to bill for Medicaid under the MOA. Rather, the MOA specifies that IHS and HCFA (now CMS) will coordinate this process with tribes. MAA acts only as a pass-through agency.

- More tribes have been able to gain representation on RSN governing boards. However, even at the request of the tribes, several RSNs are still unwilling to allow tribes to serve on their governing boards in full voting capacity.
- There is still a total lack of empirical data describing the current state of mental health of American Indians in the State of Washington.

This progress, as well as the newest issues at hand that need addressing, will be discussed in greater detail in a later part of this of this chapter. Prior to this discussion, an expanded review of the history of Washington State's mental health system, and the discussion of the meaning of culturally competency in mental health programs may be helpful.

The History of Washington State's Mental Health Care System

Washington State's current mental health system owes its roots to the community mental health movement of the late 1950s and early 1960s. The community mental health movement focused on issues surrounding the "... physical, educational, psychological, political, and social well-being of a variety of communities and populations ... it was sold politically as a way to spend less on hospital care and as a 'brick and mortar' program for new construction in many congressional districts" (Rappaport, 1991:78).

In 1963, Congress passed the Community Mental Health Centers (CMHC) Act. The intent of the CMHC Act was to better serve at-risk populations by creating local community mental health centers molded to the unique needs of the populations in each community. The CMHC Act established client care guidelines for these centers in the following five service area requirements: inpatient care, outpatient care, 24-hour emergency care, consultation services, and educational services (Ladue, 1980).

In 1967, Washington State passed the Community Health Services Act (RCW 71.24). Modeled after the CMHC Act, RCW 71.24 established legal parameters for counties to follow in providing outpatient mental health services with contract funds from the State, on a fee-for-service basis. "Counties were viewed by the state as 'pass through' entities and the counties viewed their roles as administrative" (Reinig & Hawley, 1995:235).

In 1989, 2SSB 5400 created the RSN system, which decentralized State control and transferred the planning and implementation responsibilities of outpatient mental health services to the county level (commonly referred to as phase I of mental health reform). In 1993, MHD shifted the delivery of outpatient services to a managed care model (commonly referred to as phase II of mental health reform).

> Washington's move to managed mental health care can be traced to the all 1991 changes in federal regulations related to allowable

> match for Medicaid Title XIX fee for service. In addition to these changes, the federal government informed the State of Washington that its methods of selection of mental health Title XIX providers was unacceptable and did not conform to federal regulations (the statewide Medicaid program base grew from 50 in 1986 to over 100 in 1992). In addition, the state was "maxing out" on the available match for Title XIX during a period when resources were either being capped or decreased. These developments led the State of Washington to seek a wavier from the Federal Health Care Financing Administration to waive the statewide fee for service requirement. This waiver was granted in April of 1993 for a startdate of July 1, 1993 (Reinig & Hawley, 1995:243).

The July 1, 1993 waiver gave Washington State the authority to phase in a managed care model for outpatient mental health services. Phase II was accomplished by MHD creating "... Pre-Paid Health Plans through the currently existing ... RSNs" (Thurston, 1996:7). Currently, all 14 RSNs in the State of Washington are now Pre-Paid Health Plans (PHPs). In many ways, a PHP can be described as an insurance company for Medicaid-eligible and other qualified consumers. As a PHP, the RSN has more flexibility to contract services with local providers. " ... PHPs can determine which kinds of mental health services are needed and unique to their community, and contract to provide those services without adhering to a federal definition of a 'billable' modality" (Thurston, 1996:8). These services generally "... include resource management, case management, and other community support services such as job finding, medication management, and therapeutic interventions, residential and housing supports, and crisis response intervention" (Hoppler, 1996:2).

On December 10, 1996, MHD submitted a federal waiver renewal request (pursuant to 1915B of the Social Security Act) in which authorization is requested to integrate inpatient and outpatient mental health services under a "seamless" managed care model system, commonly referred to as phase III of mental health reform. "The integrated inpatient and outpatient system of care shall be responsible to provide a seamless system of outpatient and inpatient medically necessary mental health services (on a voluntary and involuntary basis) to publicly funded persons in a way that meets individual needs" (MHD, 1996:2).

Publicly Funded Mental Health Services in the State of Washington

Washington State's mental health system has an operating budget of approximately $517,700,000 (federal and state funds) for fiscal year 2001. For the most part, state and federal law pre-determines how the majority of the funds are spent. Most non-Medicaid federal and state funds are distributed to the RSNs in a block grant based on an approved distribution formula. Title XIX Medicaid entitlement funds are distributed to the RSNs on a cost basis and must be used in direct service delivery.

RSNs do have some discretion in how they spend large portions of federal non-Medicaid funds and small portions of state-only funds. In addition, MHD manages some state and non-Medicaid federal funds that it has some discretion in spending.

In this section we discuss these funding mechanisms that support Washington State's mental health systems as a whole, and discuss the need for American Indian mental health programs to have increased access to this funding. Currently, there are some limited opportunities for American Indian mental health programs to receive funding support for pilot programs, training, personal care and emergency relief services directly from MHD. In addition, RSNs have access to funding groups that they can (and have in the past) grant to American Indian mental health programs. In order to gain access to what funding and services do exist, American Indian mental health programs must continue to take a proactive role in approaching both RSNs and MHD itself, to negotiate for these funds and services.

Also in this section, we discuss important issues surrounding crisis response and ITA services, as they relate to tribal communities. Tribal-based mental health programs take the position that, on rare occasions, crisis response and ITA services are needed for their communities. RSNs are responsible for providing these services directly or by contracting, which raises many complex jurisdiction issues. Although informal agreements tend to be in place, most tribes and RSNs have not entered into formal agreements about how these services are to be delivered on reservations and trust lands by RSNs and their providers.

Funding Mechanisms Supporting Washington State's Mental Health Care System

As state residents, Medicaid-eligible American Indian people have a legal right to receive culturally competent mental health services from Washington State's mental health system. Washington State's mental health is supported by several state and federal funding sources. The major sources of funding are: federal Title XIX Medicaid entitlement grant ($228,100,000), state-matching funds ($223,700,000), 100 percent federal mental health block grant ($7,000,000), state-only funds ($41,600,000), and local funds ($17,300,000).[46]

Currently, state and federal law pre-determines how the majority of the funds that support Washington State's mental health system are distributed. The majority of this funding is used to fund state inpatient hospitals, or is distributed in block grants to the fourteen RSNs. RCW 71.24 mandates MHD to consolidate all 'available resources' with the exception of federal Title XIX funds. Funds are distributed to the Regional Support Networks (RSNs) in a block grant based on an approved distribution formula. In addition, in most cases, state and federal law has pre-determined how the RSNs are to spend much of the funding.

[46] These estimated figures were provided by MHD.

For fiscal year 2001, MHD estimates that it will receive and spend approximately $451,800,000 in federal Title XIX Medicaid entitlement grant and state-matching funds (hereafter referred to as 50/50 Medicaid funds). Federal Title XIX Medicaid entitlement grant funds originate from the federal government and are managed by CMS, while the State Legislature appropriates state- matching funds. 50/50 Medicaid funds are considered to be a single fund, because state-matching funds are only appropriated in relation to the amount of the federal Title XIX entitlement grant, and vice versa. Therefore, 50/50 Medicaid funds are considered "fused" and treated as one, because one funding group cannot exist without the other. State and federal law mandates that 50/50 Medicaid funds be used for direct service delivery.

There is flexibility as to how MHD and RSNs can spend 100 percent federal mental health block grant and state-only funds. For the most part, state-only funds are used to support Crisis Response Teams (CRTs) that provide emergency services to all of Washington's residents, and to enforce the Involuntary Treatment Act (RCW 71.05); the ITA requires every county in the state to provide involuntary treatment services for its residents, seven days a week, twenty-four hours a day. There are minimal portions of state-only funds that are used by the RSNs for other purposes, such as training and educational services for its employees and contracted providers.

MHD distributes 100 percent federal mental health block grant funds in the following manner: 5 percent for administration costs; of the remaining 95 percent, 80 percent is distributed to the RSNs and 20 percent is managed by MHD. 100 percent federal mental health block grant funds can be used to support a wide range of pilot projects, technical assistance, training and educational services. In the past, some RSNs have distributed these funds to American Indian mental health programs to support their service capacity. Steenhout (1996) discovered that five RSNs distribute block grant funds to support American Indian mental health programs.

> The general idea behind the funding is to enable the Tribes to enhance the quality of their programs, support a specific portion of a program, and access culturally competent care. Of the five RSNs who block grant with Tribes, four cited that the main reason that they do so is because they recognize that Tribes cannot access culturally competent mental health services from contracted providers (Steenhout, 1996:48)

The grants to the nine American Indian mental health programs ranged from $5,000 to $80,000 annually; generally, these funds were used to support pilot projects, technical assistance, training, educational, tribal-specific and traditional healing services. In addition, Steenhout (1996) discovered that at least nine other American Indian mental health programs had requested block grant funds from the

RSNs in the past, but did not receive funds. Recent interviews indicate that less tribes are receiving funds from RSNS. In the future, because of state law (RCW 71.24), American Indian mental health care programs must continue to negotiate with RSNs for access to the majority of state-only and 100 percent federal mental health block grant funds.

It is very clear from our research that American Indian mental health programs are greatly in need of funding to support pilot projects, training, education and tribal-specific traditional healing services. Access to funding sources beyond 50/50 Medicaid funds, will allow the programs to improve services to their clients and build their overall capacity as a program. However, while our research did not uncover extensive funds or readily available services that American Indian mental health programs can access, we did discover some. In order to gain access to what funding and services there are, American Indian mental health programs must continue to take a proactive role in approaching both RSNs and MHD, to negotiate for these funds and services.

The Recognized Need of Crisis Response and ITA Services

RSNs are responsible for providing emergency mental health services to all State residents. The Crisis Response Teams that perform this function must provide initial screenings and assessments to determine the nature of the crisis and the course of action. These services are expected to be performed, whenever possible, on a face-to-face basis with the client in his or her community. RSNs are also responsible for providing services pursuant to the ITA. This act established County Designated Mental Health Professionals (CDMHPs); these CDMHPs are mandated to involuntarily detain individuals (until a court can review their case) who are in imminent danger of causing harm to themselves or others as a result of a mental illness. Usually, due to either financial constraints, or matters of practicality, ITA and crisis response services are provided by the same group of professionals.

Crisis Response Teams and CDMHPs are responsible for providing services to the tribal communities within their RSN's region.[47] Our research has shown that these mental health professionals recognize this responsibility. However, the responsibility to provide these services to tribal communities gives rise to controversies over jurisdiction. Steenhout (1996) found that though tribes reported Crisis Response Teams are welcome to enter their reservation in order to assist a person in crisis, tribes did not view CDMHPs as having the jurisdiction to detain a tribal community member without the consent of the tribe. This assertion may, in many cases, be in contradiction with the laws under which these mental health providers are expected to operate. As was discussed in Chapter Three, Public Law 83-280 gives the State of Washington jurisdiction over mental illness issues on most

[47] Often, RSNs have a separate group of professionals (who provide crisis response and ITA services) for each county within the RSN's catchment area.

reservations within the state (concurrent with tribal jurisdiction). Our research has found that most Crisis Response Teams and CDMHPs were unsure of who had jurisdiction, but noted that they try to coordinate their activities with tribal police and mental health professionals.[48,49]

Recent interviews have determined that, although there seems to be some informal understandings in place, most tribes still do not have formal agreements with Crisis Response Teams or CDMHPs to resolve these jurisdictional issues. Both parties should be proactive in rectifying this problem by formally agreeing to the protocol that Crisis Response Teams and CDMHPs should employ in providing services to tribal communities (i.e. ITA services will only be provided in coordination with tribal law enforcement officers). A separate agreement must be reached with each tribe.

Tribes should also be proactive in gaining an understanding of the services provided by these mental health professionals, and the constraints under which they operate. An example of these constraints is that CDMHPs are often hindered, for both legal and other reasons, in their ability to provide ITA services to individuals who are drunk. Given the prevalent role that alcohol plays in the mental health issues faced by tribal communities today, such a constraint could substantially limit the ability of CDMHPs to provide the services a tribe may need in a mental health crisis. An understanding of issues such as this will enable tribal officials to better plan for how they will serve their communities, when a mental health crisis occurs.

Another solution to many jurisdiction issues may be for the local governments to simply respect tribal court orders relating to commitments in inpatient facilities for crisis stabilization, short, or long-term treatment. In recent interviews, ten tribes stated that have the capacity and would be interested in issuing court orders requiring tribal members to undergo mental health care treatment. Additionally, at least one tribe in the State of Washington has successfully negotiated an agreement of this type with their local county government.

Addressing Culturally Specific Mental Health Issues

By Sate law, MHD has primary responsibility for ensuring the delivery of culturally competent mental health services to all of Washington State's populations. As noted earlier, outpatient mental health services are delivered to all Medicaid-eligible state residents through the RSN system. RSNs are mandated by RCW 71.24, WAC 388-865, and the terms of their contracts with MHD, to deliver culturally competent mental health services to all Medicaid-eligible state residents.

[48] Two of the thirteen CDMHPs interviewed said they would not go onto tribal land unless asked by the tribal police to do so. Two more said they had jurisdiction to provide services on tribal land without tribal permission.

[49] Steenhout (1996) found that, in a few past cases, controversies over jurisdiction had resulted in Crisis Response Teams refusing to come on to a reservations, even at the tribe's request.

This mandate puts RSNs in a challenging position since the service needs of American Indians call for providers who have specialized training, and yet very few of the programs/facilities with which the RSNs contract have culturally competent providers on staff.

In this section, we discuss the meaning of culturally competent mental health services, and explore the similarities and differences between American Indian and mainstream mental health programs in the context of culturally competent service delivery. We also discuss the failure of most RSNs to provide American Indian clients the culturally competent services that RSNs are required by law to deliver.

The Meaning of Cultural Competent Mental Health Care Services

Delivering culturally competent mental health services to American Indian populations is a very complicated endeavor. This is especially true for mainstream mental health programs (sometimes find it almost impossible to deliver such culturally competent services). In order for a provider to deliver effective mental health services to American Indian populations, the provider must be specifically trained or experienced in providing services to American Indian people. Furthermore, the provider should understand the tribal community from which a client comes, and be willing to deliver services within that community. In a general sense, for a mental health program to provide culturally competent services to an American Indian population, the program must be built upon a foundation of culturally competent service principals or, at a minimum, be willing to contract with culturally competent providers. Cross, et al. (1989) provides a comprehensive definition of cultural competence:

> Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable the system, agency, or those professionals to work effectively in cross-cultural situations. The word "culture" is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs (Cross, et al., 1989:13).

Cultural competence is the cornerstone of American Indian mental health programs (Aponte, et al., 1995; Guilment & Whited, 1989; Neligh, 1990; Swinomish, 1991). These programs take a holistic, or whole body, approach in service delivery, and address many mental illnesses that are common to American Indian populations, including those illnesses not yet formally recognized by Western medicine.

"Culturally specific approaches are psychotherapeutic methods designed to be congruent with the cultural characteristics of a particular ethnic clientele, or for problems believed to be especially prominent in a particular ethnic group or to ethnic groups in general" (Aponte, et al., 1995:76).

No two tribal-based American Indian mental health programs in Washington State use the same method of delivering culturally competent services (Steenhout, 1996). Each program is built on a foundation of the cultural values and traditions that are unique to the community where the program is located. Each program concentrates on the tribal-specific needs of that community; this approach is crucial, because mental health needs vary between tribal communities in Washington State. Service delivery involves the direct interaction of the community, the environment, and the traditions of the tribe. In most cases, programs are equipped with, or have ready access to, culturally competent professionals who are experienced in working with American Indians of that particular tribe. However, both the access to these professionals and the scope of services provided are greatly governed by access to funding.

Like tribal-based programs, American Indian urban-based programs base behavioral health program on principles of cultural competency. For example, in a document that discusses the SIHB's philosophies of mental health service delivery, its executive director comments that:

> In order for mental health services to be acceptable and well utilized, mental health services need to be culturally congruent to the people being served. Culturally congruent mental health services must not merely consider such things as client belief systems, spiritual practices, extended family relationships and child rearing practices, but must be directly derived from the culturally base of the group being served ... Values are the integral foundation in cultural and therapeutic encounters. In providing culturally specific and relevant services, values are the keystone ... Staff must familiarize themselves with and create ready access to a variety of basic services throughout the urban area. Staff should also be able to help with transportation costs of clients. The staff should be able to help access people identified in the urban and nearby community for the provision of traditional healing. Programs should incorporate into methodologies a timing approach to therapy that emphasizes spirituality, rebalancing, and healing the entire person and reintegrating him/her into the community (Forquera, 1990:358-9).

Providers in American Indian mental health programs routinely use a mixture of traditional and Western approaches to serve clientele. "Western treatments are often used concurrently with native interventions--one to cure a problem and the other to restore harmony" (Keltner, 1993:19). The applicability of each approach (traditional and Western) often depends on the client's degree of acculturation into mainstream society. As a result, mental health providers who serve American

Indian clients must be able to assess the level of a client's acculturation during the client's first few visits. "At this point, a provider can refer the client to the best resources, be it traditional, Western, or a mixture of both. A mainstream provider, who does not have a familiarity with American Indian people or the specific community the client is from, could not perform this necessary assessment" (Steenhout, 1996:43).

The Legal Responsibilities of the RSNs

RSNs are mandated by RCW 71.24, WAC 388-865, and the terms of their contracts with MHD, to deliver culturally competent mental health services to all Medicaid-eligible Washington State residents. However, with few exceptions, the RSN system has failed historically to make culturally competent services available to American Indian people (Gregory, 1991; Steenhout, 1996; Steenhout & St. Charles, 1997). In addition, Steenhout (1996) discovered during interviews with members of MHD, that it was known that " ... many RSNs follow the parameters of WAC 275-57 loosely, and that MHD had been struggling since the establishment of the RSN system to ensure that RSNs work within the parameters of WAC 275-57 on issues of cultural competence. MHD staff cited that [some] RSNs and contracted providers resisted following certain parameters of WAC 275-57" (Steenhout, 1996:52).

It is perhaps not surprising that RSNs, and the providers with which they contract, are not generally delivering the culturally competent services needed in American Indian populations. After all, American Indian mental health issues and disorders are rarely, if ever, discussed in mainstream educational systems. As a result, most professionals working outside American Indian mental health programs are ill equipped and unable to meet the service needs of American Indian people.

In some cases, RSNs block grant funds to tribes out of desperation because they cannot see another clear solution to the cultural competency issue. These grants to American Indian mental health programs detail efforts to deliver at least some culturally competent services to American Indian populations (as these RSNs seem to recognize both the importance of such programs and the fact that the RSNs' contracted providers are not capable of providing all the services needed). Generally, it is designated by contract terms between the RSN and the tribe that the funds be used for only non-clinical type training and educational services, or in support of tribal-specific, traditional healing services; however, some tribes also use the funds to contract with culturally competent providers. Funding to support traditional healing services or to contract with culturally competent providers is of great importance to American Indian mental health programs. This is true because some members of American Indian communities simply will not access Western mental health services, preferring instead to use traditional methods of healing that are specific to their tribe.

As the administrator of Washington State's mental health system, MHD has the primary responsibility of ensuring that the RSNs (PHPs) stay in compliance with RCW 71.24 and WAC 388-865; to this end, MHD is required by State law to perform a yearly review of each RSN, which MHD refers to as an Integrated Review. The following is a brief description, written by MHD, of the purpose and goals of the Integrated Review process:

> The Integrated Review of the Regional Support Networks/Prepaid Health Plans (RSN/PHP) provides an opportunity to conduct on-site activities to meet certain federal and state requirements. In addition to meeting certain requirements, a major purpose is to gain a better understanding of the overall structure and operation of the RSN/PHP and how care is being provided to individual consumers. Compliance with current rules and regulations is reviewed and corrective action taken for areas not meeting the minimum expectations. However, the scope of this review process goes beyond the minimum standards to assess the system capacity, operations and actual care in terms of best practice and the extent to which individual consumer needs are met (MHD, 1997:1).

MHD views its Integrated Review process as being in a stage of transition and development. In the past, MHD's unofficial review process only concentrated on issues of technical compliance. Now, staying in line with a mental health system that is developing into a fully managed care (seamless) system, the Integrated Review process will start to concentrate on what was described as Quality Management, as well as technical compliance issues. MHD defines Quality Management as a method of looking at the bigger picture of RSN service delivery, with regard to the efficiency of the system as a whole, rather than just reviewing an RSN's compliance with each individual technical issue (i.e. by going through WAC 388-65 section by section).

It is unfortunate that MHD has initiated a new, more developed review process that concentrates less upon technical compliance, when it is evident that such technical compliance in regard to the delivery of culturally competent services has not yet been achieved. RCW 71.24 and WAC 388-65 describe a public mental health system that is culturally competent, while in reality, most RSNs currently fail tp meet this mandate. It is not acceptable for an RSN to fail to comply with these legal mandates, but it is inexcusable for MHD to not expect such compliance.

Conclusion

American Indian communities are faced with pressing mental health needs. In this chapter we explored the two parallel, publicly funded mental health systems that American Indians in Washington State can access to meet these needs (the IHS and State systems). In the IHS system, tribes under a 638 contract operate most tribal-based mental health programs, commonly referred to as "look-alike, stand-alone,

IHS 638 programs." Urban-based programs contract with IHS under Title V of PL 94-437 (as amended) to provided mental health services to urban-based American Indians.

Many people assume that IHS provides an extensive array of mental health services to American Indians, or that IHS is the only governmental agency that has responsibility to provide services to American Indian populations; both of these assumptions are incorrect. Indian Health Services Office, which is responsible for providing IHS support health care to American Indians in Oregon, Washington, and Idaho, spent less than 2 percent of its annual budget on mental health fiscal year 2001. Furthermore, as state residents, American Indians have the right to access Washington State's mental health system on an equal basis to other residents.

In this chapter we also discussed the necessity of cultural competency in the delivery of mental health services to American Indian people, and explained the differences between these two systems in regard to such cultural competency. Cultural competence is the cornerstone of tribal-based programs. Tribal-based program providers are able to effectively assess the needs of American Indian clients and provide an effective service package that intertwines both traditional and western healing techniques.

State law mandates that MHD ensure RSNs deliver culturally competent mental health services to all Medicaid-eligible American Indians in Washington State. To date, MHD has failed to meet this mandate in regard to service delivery to American Indians. Most RSNs have also failed to provide culturally competent and accessible mental health services to American Indian people. Delivering culturally competent mental health services to American Indian populations is a very complicated endeavor; this is especially true for mainstream mental health programs, which sometimes find it almost impossible to deliver such services. In order for a provider to deliver effective mental health services to American Indian populations, the provider must be specifically trained or experienced in providing services to American Indian people. Furthermore, the provider should understand the tribal community from which the client comes, and be willing to deliver services within that community.

RSNs have the responsibility to provide crisis response and ITA services to all American Indians. American Indian mental health programs have identified that crisis response and ITA services are needed for their communities; however, in some cases, jurisdictional issues and the lack of a formal understanding (agreement) between the service providers and some tribes, complicate delivery of these services. Currently, most tribes in the State of Washington do not have formal agreements with Crisis Response Teams or CDMHPs resolving these jurisdictional issues. Both parties should be proactive in rectifying this problem by formally agreeing to the protocol that Crisis Response Teams and CDMHPs should employ in providing services to tribal communities (i.e. ITA services will only be provided in

coordination with tribal law enforcement officers). A separate agreement must be reached with each tribe.

Chapter Seven: The Impact of the MOA on American Indian Mental Health Care Programs

The Memorandum of Agreement (MOA) signed on December 19, 1996, between IHS and HCFA, created a mechanism whereby tribes and Indian organizations can build the capacity of their outpatient programs, or for some tribes, start programs. In this chapter, we discuss the impacts of the MOA on American Indians in the State of Washington.

This chapter has three sections. In the first section, we will discuss the fiscal impacts that the MOA has had on American Indian mental health care programs. In the second section, we will discuss the debate that arose between MHD, MAA, and tribes, over licensing and certification issues stemming from the MOA. Finally, in the third section, we will discuss how the MOA has not solved another key barrier issue for American Indian mental health care programs, access to the inpatient system. In fact, while tribal-based programs can be reimbursed for outpatient services provided to these clients under the MOA, these same clients are at an unfair disadvantage in accessing the State of Washington's inpatient system compared with clients in the mainstream system

The Fiscal Impact of the MOA on Tribal-Based Mental Health Programs

In this section we discuss the fiscal impacts that the MOA has had on American Indian Tribes. Our discussion will cover: 1) the controversy that arose within DSHS over the origin of the monies distributed under the MOA; 2) the levels at which tribes and Indian organizations are taking advantage of the new funding stream created by the MOA; and, 3) the different billing rate options available to tribes and Indian organizations under the MOA.

Sources of Funding Under the MOA and Clarification on the Opting-Out Issue

On December 19, 1996 (effective retroactively to July 11, 1996), IHS and HCFA signed an MOA that expanded 100 percent Federal Medical Assistance Percentage (FMAP) reimbursement to include all 638 Title I and III, tribal-based mental health programs. At the time this agreement was signed, several IHS (direct care) and three tribal-operated mental health programs in IHS facilities provided Medicaid services to American Indians; DSHS reimbursed these facilities, and was in turn reimbursed by CMS. However, if such services were reimbursed to a tribal-based program operating in a non-IHS owned or leased facility, DSHS would only receive an FMAP of roughly 100 per centum less 50 percent (i.e. if DSHS reimbursed these programs for Medicaid services, 50 percent of the costs would come directly out of the State's pocket).

As a result of the MOA, it seemed that DSHS would be reimbursed at 100 percent FMAP for amounts expended as medical assistance for services provided at all 22 tribal-based American Indian mental health programs in Washington State (regardless of whether or not a program's facility is owned or leased by IHS). Prior to the MOA, DSHS was only eligible to be reimbursed by HCFA at 100 percent FMAP for the Medicaid service costs it reimbursed to seven American Indian mental health programs operating in IHS facilities (four run directly by IHS and three run by tribes).[50]

Soon after the MOA was signed, state and tribal officials requested clarification of whether or not the Title XIX dollars distributed under the MOA were going to be deducted from the State of Washington's existing Title XIX Medicaid entitlement block grant, or if they represented new monies from Title XIX, distributed to tribes parallel to the existing state system. This was a great concern among some DSHS staff because the current make-up of the State of Washington's mental health care system created the possibility of "dual payment" of Medicaid monies for services provided to American Indian clients.

MHD noted that it is responsible for administering Medicaid funds designated to be spent on mental health and reimbursing mental health facilities that bill for Medicaid services (through the MAA System), responsibilities that would include tribal-based programs billing under the MOA. The Social Security Act (42 U.S.C. 1396d) mandates that Medicaid will be a state administered program, lays out many clear fiscal guidelines for states to follow in spending Medicaid funds, and CMS holds MHD accountable to these guidelines. MHD was concerned that CMS may demand reimbursement from the State of Washington for money distributed to tribes under the MOA, since the clients being served at the tribal-based programs could also be simultaneously receiving services within the RSN system.

Pending the clarification of the dual payment issue, MHD included language within its 1915b waiver, submitted on December 10, 1996, in which authorization was requested to integrate inpatient and outpatient mental health care services into a "seamless" managed care model system, and to give Medicaid-eligible American Indians the choice of disenrolling from the RSN (outpatient services only), instead receiving services at tribal-based mental health programs. Once the 1915b waiver is signed by HCFA (i.e. phase III begins), Medicaid-eligible American Indian people will remain enrolled in the PHP like other eligible residents in the State; however, at their request, any Medicaid-eligible American Indian may choose to disenroll from the PHP, and instead receive Medicaid reimbursable services from a tribal-

[50] Under the MOA, DSHS was not eligible for reimbursement at 100 percent FMAP for amounts expended as medical assistance for services provided at urban-based programs operating under Title V of PL 94-437; this is because the MOA, as it is currently written, does not include programs operating under Title V of PL 94-437 that are not operating in IHS owned or leased facilities.

based American Indian mental health program that has met the above discussed criteria. A disenrolled client could re-enroll in the PHP at any point they so desired.

When an American Indian disenrolled (opts-out) from the PHP, MHD planed to deduct the equivalent of one client's share of the federal Title XIX Medicaid and state-match funds (50/50 Medicaid funds), from the PHP in which the client was originally enrolled. However, since state-only and 100 percent federal mental health block grant funds (not 50/50 Medicaid funds) support RSN crisis response teams and ITA services, these responsibilities will remain with the RSNs and the counties (even for a disenrolled client).

Soon after MHD's 1996 waiver request was submitted, CMS clarified that the Title XIX dollars distributed under the MOA would not be deducted from the State of Washington's existing Title XIX Medicaid entitlement block grant. These Medicaid monies would be distributed to tribes outside of the existing state system, thus creating parallel systems funded by Medicaid that American Indians could access. CMS also noted that there was no need for American Indians to opt-out of the PHP in order to receive services at tribal-based programs.

Fiscal Impacts of the MOA on Tribes

The MOA has provided an excellent funding stream for tribal-based mental health care programs. However, many tribes and Indian organizations are not currently accessing this resource. Of the twenty-nine federally recognized tribes in the State of Washington, twenty-two have tribal-based mental health care programs currently operating (one of which is operated by IHS directly). Only twenty of these tribes have obtained provider numbers for their mental health programs to bill under the MOA. Of these twenty tribes, only twelve seem to be actively billing. Between January and September of 2001, MAA estimates that these programs have billed for a combined $2.5 million in Medicaid reimbursement. Several programs are on track to bill for several hundred thousand dollars before years end, while others have billed for less than $25,000.

Our recent interviews indicate that there are at least four tribes and several Indian organizations that are currently providing some type of billable mental health cares services, and yet have not obtained a provider number and not currently billing. Overall, nine of the ten tribes not currently billing wish to do so in the near future.

Reimbursement Rate Options for Tribal-Based Mental Health Programs

Under the MOA, tribal-based mental health care programs are eligible to receive reimbursement for Medicaid services provided to eligible clients by billing under one of two general rates, the OMB encounter rate or the FQHC rate. In addition, these programs may bill under the prevailing Medicaid FFS rate for other services and products not provided by the OMB encounter and FQHC rates.

The OMB encounter rate is a one-time payment that represents the average cost of care at a federal facility (this rate is also commonly referred to as the FMAP rate or the IHS rate). The OMB encounter rate is federally determined (through negotiations between IHS and CMS), and is currently $185 per encounter for facilities nationwide.

The FQHC rate is more complicated. Any American Indian health program operating under 638 contracts (Title I and III programs) or urban-based programs receiving funds under Title V of PL 94-437 (i.e. the SIHB), can be designated as an FQHC. In order to be an FQHC, the program must meet one of the following criteria:

> 1) receiving grants under section 329, 330, or 340 of the Public Services Act; OR 2) receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant, OR 3) a tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL 93-638). Only Health Care Financing Administration-designated FQHCs will be allowed to participate in the program (MAA, 1994:3).

Any American Indian health program in Washington State can be designated as an FQHC simply by requesting designation by CMS (except programs run directly by IHS in IHS owned or leased facilities); if the American Indian health program that has been designated as an FQHC has a mental health program, the program can bill at a pre-determined FQHC rate for Medicaid services provided to eligible clients (often referred to as billing under the umbrella of an FQHC health facility).

Prior to billing as an FQHC, the American Indian mental health program must obtain a provider number from MAA and a rate of reimbursement must be determined for the program. Once the provider number is assigned, a rate of reimbursement is determined through information sharing between MHD and the program; a program's FQHC rate is determined by generating a "cost report" based on what it costs an individual program to deliver services. Thus, every American Indian mental health program would have an FQHC rate that is unique to each program. Generally, MHD makes "... its own rules as to how the rate is calculated and what is a reasonable way of applying administrative and general costs, and the calculations are set out in a prescribed set of forms ... [the] rate request must be backed up by documentation from service reports and financial records, and will be subject to annual review by a DSHS auditor" (Decktor, 1996:2).

Once MHD and the American Indian mental health program agree on what the program's FQHC rate will be, the program can then bill at this rate on an encounter basis, much like the OMB encounter rate. On a monthly basis, total reimbursement

payments to the program are compared to the financial records (which show number of encounters) provided by the program, and reconciliation payment is made to balance the difference between the amounts (i.e. MHD may owe the program money, or vice versa). On a yearly basis, the program's FQHC rate is re-examined in an audit of the yearly receipts, and from this analysis a new FQHC rate may be determined for the coming year.

In addition to the OMB encounter and FQHC rates, tribal-based mental health programs can bill for some services and products not provided by the OMB encounter and FQHC rates. This billing will occur through the currently prevailing Medicaid FFS rate and include items such as transportation and prescription drugs. American Indian mental health programs must determine what is billable under the prevailing Medicaid FFS rate through negotiations with MHD at the time each program submits its cost-report.

When deciding what rate to bill under the MOA, tribes should consider the amount of revenue that can be potentially raised under each rate, and how each rate impacts tribal sovereignty. The OMB encounter rate will provide a consistent flat reimbursement rate of $185 per encounter. Since an FQHC rate is unique to each program, it is unknown what the total reimbursement amount would be for any one program, unless a cost report is first generated. In a paper written concerning cost reports for FQHC facilities, Dr. Shulamit Decktor (a financial management consultant), stated that with "... reasonably good records and a fairly comprehensive program, a rate of about $100 per visit can be established. A well-integrated program with good records would have a higher rate" (Decktor, 1996:2).

In regard to tribal sovereignty, from our analysis, it would seem that programs billing under the OMB encounter rate would have less physical contact with State agencies than billing under the FQHC rate. In addition, compared to the FQHC rate, the OMB encounter rate does not require as much auditing or extensive paperwork. Based on these facts, one might conclude that the OMB encounter rate is less imposing on the sovereignty of tribes, and requires less bureaucratic red-tape when compared with the FQHC rate. In addition, the OMB rate would be the best rate for smaller programs, that are only able to provide a limited array of services (thereby not being able to build an extensive cost report).

Under current state law, Tribal-based mental health programs can bill Medicaid retroactively up to 365 days after services were provided to eligible clients. Therefore, once a tribal-based program obtains a provider number, they can "back-bill" for up to one year for services provided to eligible client, granted the program has kept appropriate client records. One important issue still being clarified by CMS is whether or not Tribes should be able to bill retroactively back to the MOA effective date of July 11, 1996. Many tribes take the position that federal and state officials should not penalize them for the slow implementation of the MOA.

Federal, State, and Tribal Responsibilities Under the MOA

Soon after the signing of the MOA, debate quickly developed between MHD, MAA, and tribes over licensing and certification issues. At the root of the issue were the State of Washington's concerns over their level of legal liability as the Medicaid authority, and the failure of IHS to follow through with their commitments under the MOA. Once the State obtained a legal opinion from the Attorney General Office that alleviated its liability concerns, discussions shifted to certification and licensing issues. This section will discuss the licensing and certification issues raised by the MOA.

The Licensing of American Indian Mental Health Programs

Within the MOA, IHS and HCFA defined licensing (accreditation) criteria that tribal-based American Indian mental health programs must meet prior to HCFA reimbursing states at 100 percent FMAP for payments made to these programs. In regard to the licensing prerequisites, it is stated in the MOA that:

> In implementing 100-percent FMAP for tribal 638 facilities, HCFA and IHS acknowledge that these facilities must meet all conditions and requirements applicable under the Medicaid statue and will encourage either state certification or accreditation by a recognized accreditation body, such as JCAHO, for all tribal facilities that participate in their programs. Current Medicaid regulations require a state plan provide that an IHS facility meeting state requirements for Medicaid participation must be accepted on the same basis as any other qualified provider. However, when state licensure is normally required, the regulations provide that the IHS facility need not obtain such a license but must meet all applicable standards for licensure. With the new interpretation that tribally owned and operated 638 facilities are "IHS facilities," such 638 facilities must meet all applicable standards for licensure but not obtain a state license (Trujillo & Vladeck, 1996:3-4).

Undoubtedly, licensing issues were the most hotly debated issue at the outset of the implementation of the MOA in the State of Washington. MHD investigated the issue of how it would ensure that tribes were operating their programs equal to state standards. As mentioned earlier in this chapter, MHD stressed that it was responsible for administering Medicaid funds within federal guidelines, even those distributed under the MOA. In addition, MHD felt that it might potentially open itself to judicial review if it failed to require licensing or accreditation prior to allowing the programs to bill for Medicaid services.

Under the MOA, IHS took responsibility for negotiating with tribes and tribal organizations to include in any 638 agreement, tribal quality of care standards necessary to meet state licensure, accreditation, or certification requirements. IHS

also agreed to provide CMS with a list of programs meeting these standards each fiscal year, which in turn CMS would provide to the State of Washington. To date, this list has never been provided to the State of Washington. IHS holds the position that 638 programs program standards are equal to state standards and all tribal-based programs in the State of Washington currently operate under 638 contracts.

Soon after the signing of the MOA, professionals representing MHD, interested tribes, and Indian organizations, worked collaboratively to address licensing issues. The outcome of this work resulted in the creation of a licensing alternative for those tribal-based American Indian mental health programs that did not wish to be licensed by the State of Washington and were not nationally accredited. Under the alternative, tribal councils would certify their own programs under a standard equal to the State of Washington standards. At least 10 tribes in the State of Washington entered into an intergovernmental agreement with MHD under this standard. In essence, the purpose of this alternative standard was to "kick-start" the MOA billing process, as HCFA and IHS had continued discussions over licensing issues under the MOA.

Presently, MHD is no longer utilizing this alternative standard for two reasons: 1) it seems clear that tribes already operate their mental health programs within high professional standards, and 2) since the signing of the MOA, both CMS and IHS have clearly stated that licensing and certification of tribal-based programs billing under the MOA is an issue between tribes and the federal government. In effect, MAA acts as a pass-through agency, due to their role as the State of Washington's Medicaid authority. Furthermore, MHD has no jurisdiction under the MOA.

In regard to program standards, a recent study found that every mental health provider working in American Indian mental health programs in Washington State held the appropriate state license or certification for their discipline (Steenhout, 1996).[51] Recent interviews have found that, with few exceptions, tribal-based mental health programs in the State of Washington continue to operate within these same standards of certification and licensure.

Steenhout and St. Charles (1997) determined that three tribal-based mental health programs in Washington State are currently licensed by MHD,[52] and seven tribal-based programs currently had JCAHO accreditation.[53] JCAHO has provided behavioral health care accreditation services to providers offering mental health, chemical dependency, and mental retardation/developmental disabilities services since 1969. JCAHO is the leading accreditation body of health care organizations in the United States; they accredit over 14,000 health care organizations, including

[51] In the original study, one mid-level provider was uncertified, but working toward attaining certification. Within two weeks of publishing the study, it was verified by the author that this person did in fact receive state certification.
[52] These programs are located at the Puyallup, Quileute and Tulalip Tribes.
[53] These programs are located at the Colville, Puyallup, Spokane, Makah, and Quinault Tribes, and at the Lummi and Yakama Indian Nations.

1,800 organizations providing mental health and disability services. The JCAHO standard is recognized by American Indian mental health programs as being the very finest (Neligh, 1990), and will likely fulfill the accreditation prerequisites of Washington State under phase III.

Recent interviews also indicate that tribal-based programs continue to operate within 638 contact program standards. As mentioned earlier, all 22 American Indian mental health programs in Washington State meet IHS program standards; this is fundamental to their operation under 638 contracts, as they must meet these standards prior to receiving funding. This understanding is bonded by a contract between IHS and American Indian mental health programs. Programs operating under IHS standards continually strive to promote, provide, and manage a comprehensive system of mental health services that are culturally competent. "Services should also be provided in ways that are culturally sensitive and responsible to the individual, family, and tribal community" (Nelson, et al., 1992:260). IHS standards require that providers of mental health services are fully competent, certified, or licensed in the discipline in which they practice.

With many tribal-based mental health programs increasing their revenues by billing under the MOA, national accreditation is becoming a more viable option for these programs. While JCAHO accrediation can be quite costly, CARF and AAAHP offer three-year accreditation for between $3,700 and $5,000 per three-year period. Both of these organizations stated that they have had great success in accrediting American Indian behavioral health programs in the past. Tribal-based mental health programs that do not currently hold national accreditation should consider doing so in the future. These programs should have no problem meeting accreditation standards, and by obtaining this accreditation, these programs would lay to rest all questions concerning the level professionalism by which these programs currently run. Furthermore, by gaining national accreditation, tribal-based programs are in a much better position to negotiate for access to the State of Washington's inpatient system, and compete for grant funding from state, federal, and private organizations.

Access to the State of Washington's Inpatient System

Tribes in the State of Washington are building their program capacity through billing under the MOA. The MOA has provided the opportunity for Medicaid eligible American Indians to more easily access culturally competent mental health care services. However, while the MOA has created an environment where tribal-based programs can be reimbursed for services provided to clients, these same clients are at an unfair disadvantage in having access the State of Washington's inpatient system compared with clients in the mainstream system. In this section we discuss these issues and the need for further research to define the inpatient needs of America Indians in the State of Washington.

RSNs as Gatekeepers to the Inpatient System

Under the current structure of the State of Washington's Inpatient Mental Health Care System, all clients must be assessed by a designated non-Indian outpatient facility to gain admission to an inpatient bed.[54] This fact creates significant barriers for American Indians receiving outpatient treatment at tribal-based mental health care programs that may require admission to an inpatient facility. As mentioned earlier, American Indians have access to both the RSN and tribal-based outpatient programs, but tend to choose the services of American Indian mental health programs, where culturally competent care is available. At the point that a client in a tribal-based program is in need of inpatient care, the tribal-based program must negotiate with the designated RSN provider to access a bed, even though the RSN provider may not have any prior experience with the client or experience serving American Indians.

Our recent interviews found that RSN providers routinely disagree with tribal-based program assessments, denying access to beds. Of course, it is not entirely clear why this happens. One possibility is that inpatient beds are a limited resource and RSN providers are sometimes faced with the hard decision of denying a needy client access based on a lack of resources. On the other hand, several tribes commented that the RSN provider routinely disagrees with their assessments, which they attribute to communication breakdowns and a lack of cultural competence. Several other Tribes commented that once they take their clients offsite (i.e. away from their community and comfort zone), the client tends to go into type of "survivor mode," often denying earlier comments and actions. Since the RSN provider has not witnessed the earlier behavior, they have no choice but to deny the admission. Other tribes feel that they denied access to these resources as a result of poor relations with the county governments.

Level of Need for Inpatient Services

It is not entirely clear what the current level of need for inpatient services is among clients served by tribal-based mental health care programs. In order to get a rough idea of what this need may be, we informally polled tribal-based programs across the State of Washington. The following are our findings:

- Most tribes estimated their need for an inpatient placement within the range of one to five cases annually.
- Four tribes estimated a much higher unmet need, at ten, fifteen, sixteen, and twenty-four cases per year respectively.

[54] There is one partial exception to this current situation. The North Sound RSN has worked with tribes to develop a model where tribal-based mental health programs can initiate voluntary admission to inpatient services. Two tribes are currently utilizing this model, which will be discussed in greater detail in a later part of this section.

- A rough statewide annual estimate for the need of tribal-based mental health care programs would be about 130-150 cases.
- These 130-150 cases could be split pretty evenly (50/50) between youth and adults.
- Additionally, at least 70 percent of these 130-150 cases would be dual diagnosed clients.
- Finally, about 60 percent of these 130-150 cases would be short-term, crisis stabilization situations.

There are few issues currently more important to tribal-based mental health care programs than improving access to the inpatient system. As a result, IPAC and/or the AIHC should initiate a study to more clearly define the current inpatient needs of tribes in the State of Washington. At a minimum, this study should attempt to more clearly define the quantity of need, estimate approximate annual cost to meet this need, and define what would be culturally competent inpatient services for American Indians.

Models to Improve Access to the Inpatient System

Although it is clear that there are significant barriers for American Indians served by tribal-based mental health care programs who need access the State of Washington's inpatient system, it is not entirely clear how to improve access. Tribal-based mental health care programs have few relationships built with RSNs, and their contract outpatient providers designated to conduct inpatient placements, which would allow reasonable access to the inpatient system.

One RSN that has worked to become the exception to this rule is the North Sound RSN (NSRSN). There are eight tribes within the NSRSN service area and this RSN has an active tribal liaison. In collaboration with the tribes, the NSRSN has developed a mechanism under the auspices of their 7.01 Plan, by which tribal-based programs have authority to initiate certification for voluntary admissions to inpatient services. Two of the eight tribes are currently conducting their own placements. The systemic requirements for tribes conducting their own placement include:

- Clients must be Medicaid eligible and receiving services at a tribal-based program.
- Admission criteria must be consistent with the NSRSN criteria.
- Tribes must coordinate procedures with the NSRSN regarding client certification.
- Tribes will meet all qualifications and standards in accordance with WAC, RCW and other mental health licensure standards.

- Participating Tribes will provide methodology and implementation documentation for planning inpatient treatment needs and discharge planning.

While the NSRSN model seems to be a positive example of Indian-non-Indian, government-to-government collaboration, this model is not a realistic one to solve the statewide problem of access to the inpatient system. As mentioned before, historical relationships between tribes and other governments in the State of Washington have been worst at the local level. The RSN system is no exception, and RSNs across the State of Washington are not going to voluntarily work in good faith with tribes on inpatient access issues.

Most state-based solution options would require the revising of the Community Mental Health Care Services Act (RCW 71.24), which is not realistic based on the outcome of attempts by tribes in the past seeking a legislative solution to their problems with the RSN system. A few of these options would include:

- Allow tribes to form a single, or multiple, RSNs among themselves or with neighboring county governments.
- Require RSNs to coordinate directly with tribes on inpatient placements, removing their contracted providers from the process altogether.
- Require MHD to coordinate directly with tribes on inpatient placements, removing RSNs from the process altogether.
- Redirect of portion of inpatient funding to create beds that tribes could access directly.
- Redirect a portion of inpatient funding to create mental health bed space in the four existing Alcohol and Drug Addiction Treatment and Support Act (ADATSA) facilities in the State of Washington that specialize in the treatment of American Indians (this could be the easiest way to improve services to the dually diagnosed).

A more realistic option would be to approach CMS with the plan to fund "Evaluation and Treatment" and "Community Hospital" type beds for tribes that are funded with 100 percent federal dollars. As mentioned earlier, the MOA has created an opportunity for tribes to build the capacity of their outpatient programs; however, when tribal-based program providers feel an inpatient stay is necessary for one of their clients, there are no realistic options for tribes to access this service. CMS seems to be the only entity that can realistically solve this access problem, which must be done outside of the local government controlled RSN system. Whether or not CMS has access to the funding necessary to solve this problem of access is another matter.

Conclusion

The MOA has provided an excellent funding stream for tribal-based mental health care programs. However, many tribes and Indian organizations are not currently accessing this resource. Of the twenty-nine federally recognized tribes in the State of Washington, twenty-two have tribal-based mental health care programs currently operating (one of which is operated by IHS directly). Only twenty of these tribes have obtained provider numbers for their mental health programs to bill under the MOA. Of these twenty tribes, only twelve seem to be actively billing. Between January and September of 2001, MAA estimates that these programs have billed for a combined $2.5 million in Medicaid reimbursement. Several programs are on track to bill for several hundred thousand dollars before years end, while others will likely bill for less than $25,000.

When deciding what rate to bill under the MOA, tribes and Indian organizations should consider the amount of revenue that can be potentially raised under each rate, and how each rate impacts tribal sovereignty. The OMB encounter rate will provide a consistent flat reimbursement rate of $185 per encounter. Since an FQHC rate is unique to each program, it is unknown what the total reimbursement amount would be for any one program until a cost report was generated. Compared to the FQHC rate, billing under the OMB encounter rate requires less physical contact with State agencies and does not require as much auditing or extensive paperwork.

Within the MOA, IHS and HCFA defined licensing (accreditation) criteria that tribal-based American Indian mental health programs must meet prior to HCFA reimbursing states at 100 percent FMAP for payments made to these programs. Under the MOA, IHS has the continued responsibility for negotiating with tribes and tribal organizations to include in any 638 agreement tribal quality of care standards necessary to meet state licensure, accreditation, or certification requirements. MAA simply acts as a pass-through agency, due to their role as the State of Washington's Medicaid authority. Furthermore, MHD has no jurisdiction under the MOA.

Recent interviews also indicate that tribal-based programs continue to operate with 638 contact program standards. As mentioned earlier, all 22 tribal-based mental health care programs in Washington State meet IHS program standards; this is fundamental to their operation under 638 contracts, as they must meet these standards prior to receiving funding. This understanding is bonded by a contract between IHS and American Indian mental health programs. Programs operating under IHS standards continually strive to promote, provide, and manage a comprehensive system of mental health services that are culturally competent. IHS standards require that providers of mental health services are fully competent, certified, or licensed in the discipline in which they practice.

With some tribal-based mental health programs increasing their revenues by billing under the MOA, national accreditation is becoming a more viable option for these programs. Several national accreditation organizations, such as JCAHO and CARF, noted that they have not had any problem with accrediting tribal-based programs. By gaining national accreditation, tribal-based programs are in a much better position to negotiate for access to the State of Washington's inpatient system, and compete for grant funding from state, federal, and private organizations.

Under the current structure of the State of Washington's Mental Health Care System, American Indians receiving services at tribal-based mental health care programs face significant barriers to accessing inpatient services. Our recent interviews found that RSN providers routinely disagree with tribal-based program assessments, denying access to beds. This seems to be due to limited resources, communication breakdowns, a lack of cultural competence among RSN providers, and poor relations between tribes and local governments.

It is not entirely clear what is the current level of need for inpatient services among clients served by tribal-based mental health care programs. In order to get a rough idea of what this need may be, we informally polled tribal-based programs across the State of Washington to get a ballpark figure. The results were that most tribes estimated their need for an inpatient placement within the range of one to five cases annually, while four tribes estimated a much higher unmet need, at ten, fifteen, sixteen, and twenty-four cases per year respectively. A rough statewide annual estimate for the need of tribal-based mental health care programs would be about 130-150 cases, split pretty evenly between youth and adults, of which at least 70 percent would be dual diagnosed clients, and 60 percent of the cases being short-term, crisis stabilization cases.

There are few issues currently more important to tribal-based mental health care programs than improving access to the inpatient system. A workgroup should be established between tribal, federal, and state officials to more clearly define the current inpatient needs of tribes in the State of Washington and how tribes can achieve fair and equitable access to these services. Attempts should be made to clearly define the quantity of need, estimate approximate annual cost to meet this need, and define what would be culturally competent inpatient services for American Indians.

Although it is clear that there are significant barriers for American Indians served by tribal-based mental health care programs who need access to the State of Washington's inpatient system, it is not entirely clear how to improve access. Tribal-based mental health care programs have few relationships built with the RSNs and their contract outpatient providers designated to conduct inpatient placements that would allow reasonable access to the inpatient system.

Most state-based solution options for the lack of access that tribes have to inpatient services would require the revising of the Community Mental Health Care Services Act (RCW 71.24), which is not realistic based on the outcome of attempts in the past by tribes seeking a legislative solution to their problems with the RSN system. A more realistic option would be to approach CMS with the plan to fund "Evaluation and Treatment" and "Community Hospital" type beds for tribes that are funded with 100 percent federal dollars. CMS seems to be the only entity that can realistically solve this access problem, which must be done outside of the local government controlled RSN system. Whether or not CMS has access to the funding necessary to solve this problem of access is another matter.

Chapter Eight: Conclusions

Similar to national trends, American Indians in Washington State suffer from high rates of mental health problems such as depression, substance abuse, destructive "acting-out" type behaviors (such as suicide, fighting, and acting recklessly), and many other types of mental illnesses that are not formally recognized by Western science. The extent of mental health problems in American Indian populations is especially telling when prevalence data is compared with that of other ethnic groups. American Indian children in Washington State seem to be most at risk, with shocking rates of SED, suicide, and substance abuse. Between 70-90 percent of clients being served by tribal-based mental health programs are dually diagnosed, suffering from both mental health and substance abuse problems.

The mental health issues currently faced by American Indians, as well as the difficulties tribal communities have in addressing those issues, are substantially a product of the history of Indian-non-Indian relationships in this country. The value systems, beliefs and motivations of European Americans have, over time, given rise to numerous governmental policies and practices which, along with the disruptions caused by European introduced diseases, have resulted in a history marked by the subjugation, impoverishment, and cultural degradation of American Indian communities. This subjugation, impoverishment and cultural degradation has, in turn, greatly contributed to the high levels of depression, alcoholism and destructive acting-out behavior among American Indians today. Furthermore, it has partially undermined the ability of many American Indian communities to fully respond to these mental health problems.

Most American Indians in Washington State receive mental health services at tribal- and urban-based American Indian mental health programs. American Indians choose to receive services at these programs because they offer culturally competent care and are more accessible than mainstream programs. Delivering culturally competent mental health services to American Indian populations is a very complicated endeavor, especially for mainstream mental health programs which sometimes find it almost impossible to deliver such services. In order for a provider to deliver effective mental health services to American Indian populations, the provider must be specifically trained or experienced in providing services to American Indian people. Furthermore, the provider should understand the tribal community from which the client comes, and be willing to deliver services within that community.

Many people assume that IHS provides an extensive array of mental health services to American Indians, or that IHS is the only governmental agency that has the responsibility to provide services to American Indian populations; both of these assumptions are incorrect. First, IHS has budgeted only 2 percent of its fiscal year

2001 budget for mental health. Second, as state residents, American Indians have the right to access Washington State's mental health system on an equal basis to other residents. Although the need for mental health services for American Indian populations in Washington State is apparent and great, it seems clear that the federal government and the State of Washington are far from meeting these compelling service needs.

RSNs are mandated by RCW 71.24, WAC 388-865, and the terms of their contracts with MHD, to deliver culturally competent mental health services to all Medicaid-eligible Washington State resdients. However, with few exceptions, the RSN system has failed to make culturally competent services available to American Indian people. By State law, MHD has primary responsibility for ensuring that the RSNs (PHPs) deliver culturally competent mental health services to all Medicaid-eligible American Indians in Washington State; to date, MHD has failed to enforce this mandate.

RSNs have the responsibility to provide crisis response and ITA services to all American Indians. American Indian mental health programs have identified that crisis response and ITA services are needed for their communities; however, in some cases, jurisdictional issues and the lack of a formal understanding (agreement) between the service providers and some tribes complicate delivery of these services. Currently, most tribes in the State of Washington do not have formal agreements with Crisis Response Teams or CDMHPs to resolve these jurisdictional issues. Both parties should be proactive in rectifying this problem by formally agreeing to the protocol that Crisis Response Teams and CDMHPs should employ in providing services to tribal communities (i.e. ITA services will only be provided in coordination with tribal law enforcement officers). Separate agreement must be reached with each tribe.

The MOA has provided an excellent funding stream for tribal-based mental health care programs. However, many tribes and Indian organizations are not currently accessing this resource. Of the twenty-nine federally recognized tribes in the State of Washington, twenty-two have tribal-based mental health care programs currently operating (one of which is operated by IHS directly). Only twenty of these tribes have obtained provider numbers for their mental health programs to bill under the MOA. Of these eighteen tribes, only twelve seem to be actively billing. Between January and September of 2001, MAA estimates that these programs have billed for a combined $2.5 million in Medicaid reimbursement. Several programs are on track to bill for several hundred thousand dollars before years end, while others will likely bill for less than $25,000.

When deciding what rate to bill under the MOA, tribes should consider the amount of revenue that can be potentially raised under each rate, and how each rate impacts tribal sovereignty. The OMB encounter rate will provide a consistent flat reimbursement rate of $185 per encounter. Since an FQHC rate is unique to each

program, it is unknown what the total reimbursement amount would be for any one program until a cost report is generated. Compared to the FQHC rate, billing under the OMB encounter rate requires less physical contact with State agencies and does not require as much auditing or extensive paperwork.

Within the MOA, IHS and HCFA defined licensing (accreditation) criteria that tribal-based American Indian mental health programs must meet prior to HCFA reimbursing states at 100 percent FMAP for payments made to these programs. Under the MOA, IHS has the continued responsibility for negotiating with tribes and tribal organizations to include in any 638 agreement tribal quality of care standards necessary to meet state licensure, accreditation, or certification requirements. MAA acts as a pass-through agency, because of their role as the State of Washington's Medicaid authority. Furthermore, MHD has no jurisdiction under the MOA.

Recent interviews also indicate that tribal-based programs continue to operate with 638 contact program standards. As mentioned earlier, all twenty-two American Indian mental health programs in Washington State meet IHS program standards. Meeting these standards is fundamental to their operation under 638 contracts, as they must meet the standards to receiving funding. This understanding is bonded by a contract between IHS and American Indian mental health programs. Programs operating under IHS standards continually strive to promote, provide, and manage a comprehensive system of mental health services that are culturally competent. IHS standards require providers of mental health services are fully competent, certified, or licensed in the discipline in which they practice.

Many tribal-based mental health programs are increasing their revenues by billing under the MOA, and as a result, national accreditation is becoming a more viable option for these programs. Several national accreditation organizations, such as JCAHO and CARF, noted that they have not had any problems accrediting tribal-based programs. By gaining national accreditation, tribal-based programs are in a much better position to negotiate for access to the State of Washington's inpatient system, and compete for grant funding from state, federal, and private organizations.

Under the current structure of the State of Washington's mental health care system, American Indians receiving services at tribal-based mental health programs face significant barriers to accessing inpatient services. Our recent interviews found that RSN providers routinely disagree with tribal-based program assessments, denying access to beds. This seems to be due to limited resources, communication breakdowns, a lack of cultural competence among RSN providers, and poor relations between tribes and local governments.

Currently, it is not entirely clear what is the current level of need for inpatient services among clients served by tribal-based mental health care programs. In

order to get a rough idea of what this need is, we informally polled tribal-based programs across the State of Washington. The results were that most tribes estimated their need for an inpatient placement within the range of one to five cases annually, while four tribes estimated a much higher unmet need, at ten, fifteen, sixteen, and twenty-four cases per year respectively. A rough statewide annual estimate for the need of tribal-based mental health care programs would be about 130-150 cases, split pretty evenly between youth and adults, of which at least 70 percent would be dual diagnosed clients, and 60 percent of the cases being short-term, crisis stabilization cases.

There are few issues currently more important to tribal-based mental health care programs than improving access to the inpatient system. A workgroup should be established between tribal, federal, and state officials to more clearly define the current inpatient needs of tribes in the State of Washington and how tribes can achieve fair and equitable access to these services. Attempts should be made to clearly define the quantity of need, estimate approximate annual cost to meet this need, and define what would be culturally competent inpatient services for American Indians.

Although it is clear that there are significant barriers for American Indians served by tribal-based mental health care programs who need access the State of Washington's inpatient system, it is not entirely clear how to improve access. Tribal-based mental health care programs have few relationships built with RSNs, and their contract outpatient providers designated to conduct inpatient placements, which would allow reasonable access to the inpatient system.

Most state-based solution options for the lack of access that tribes have to inpatient services would require the revising of the Community Mental Health Care Services Act (RCW 71.24), which is not realistic based on the outcome of attempts by tribes in the past seeking a legislative solution to their problems with the RSN system. A more realistic option would be to approach CMS with the plan to fund "Evaluation and Treatment" and "Community Hospital" type beds for tribes that are funded with 100 percent federal dollars. CMS seems to be the only entity that can realistically solve this access problem, which must be done outside of the local government controlled RSN system. Whether or not CMS has access to the funding necessary to solve this problem of access is another matter.

Chapter Nine: Policy Recommendations

In this chapter we offer several recommendations for policy change and future inquiry. These recommendations are the product of our research effort. Many of these recommendations were provided by representatives of American Indian mental health care programs, or employees of local and state governmental agencies. Some of the recommendations are our own. The underscored text is the specific recommendation, while the other text provides background or summary information.

1. The OMB encounter rate provides reimbursement of $185 per encounter to tribal-based mental health care programs. On the other hand, the FQHC rate is unique to each program, and it is therefore unknown what the total reimbursement amount would be for any one program, until a cost report is generated. From our analysis, it seems that the OMB rate would be the best rate for tribal-based programs to utilize for three reasons: first, by utilizing the OMB encounter rate, tribal-based programs would have less physical contact with state agencies than with the FQHC rate (as a result, it seems that the OMB encounter rate would be less imposing on tribal sovereignty); second, the OMB encounter rate does not require as much auditing or extensive paperwork, compared with the FQHC rate (and therefore would entail less ongoing technical costs); third, it seems that the OMB encounter rate would generate more revenue for most programs (especially smaller programs that are only able to provide a limited array of services).

2. It is well established that the federal government (not local or state government) has the primary responsibility to provide health care to American Indians; this obligation is implicit in the treaties and has been explicitly set forth in a series of federal laws, executive orders, and court decisions. This obligation stems from the federal government's trust relationship with tribes. However, the declaration within the Social Security Act that mandates that Title XIX Medicaid funds will be managed by states, contradicts the federal government's obligations to American Indian people. The mandate places American Indian tribes in an awkward position where they must negotiate with states and local governments rather than the federal government, in order to access Medicaid funds. The mandate also puts state and local governments in a difficult position. States have a legal responsibility to manage Medicaid and provide (manage) Medicaid supported mental health services to all state residents (including American Indians); however, states do not have jurisdiction over tribal communities and are therefore limited in their ability to provide these services to tribal communities as effectively as they do to other populations. With respect to the unique legal status that tribes hold with the federal government and the federal government's trust responsibility to tribes, it would be more fitting if tribes were accessing Title XIX Medicaid funding directly from CMS,

rather than DSHS; a change in the way the federal government distributes federal Title XIX Medicaid funds may require a change in the Social Security Act. Tribes and CMS should collaboratively address the issues surrounding why tribes must currently access Medicaid funds through state governments rather than the federal government.

3. By State law, MHD has primary responsibility for ensuring that the RSNs deliver culturally competent mental health services to all Medicaid-eligible American Indians in Washington State; to date, MHD has failed to meet this mandate, as most RSNs (PHPs) have failed to provide culturally competent and accessible mental health services to American Indian people. In the future, MHD must ensure that RSNs provide culturally competent mental health services to all their clients, including American Indians (i.e. ensuring RSNs comply with RCW 71.24, WAC 388-865, and MHD contract terms).

4. Culturally competent mental health services are rarely available for American Indian people through the RSN System. In the future, RSNs could meet their legal obligation to provide culturally competent services to American Indian people by contracting with providers from American Indian mental health programs.

5. RSNs are responsible for providing emergency mental health services to clients within their regions. RSNs are also responsible for providing services pursuant to the Involuntary Treatment Act; the ITA established County Designated Mental Health Professionals (CDMHP), which is the only entity that can legally detain individuals involuntarily (until a court can review their case) who are in imminent danger of causing harm to themselves or others as a result of a mental illness. RSNs must provide this service to tribal communities by law, and yet this responsibility creates controversies over jurisdiction. Most tribes do not have formal agreements with Crisis Response Teams or CDMHPs to resolve these jurisdictional issues. Both parties should be proactive in rectifying this problem by formally agreeing to the protocol that Crisis Response Teams and CDMHPs should employ in providing services to tribal communities (i.e., ITA services will only be provided in coordination with tribal law enforcement officers). Separate agreements should be reached with each tribe.

6. The governing boards of RSNs make the primary decisions regarding how RSN money is spent (aside from state and federal mandates that set forth spending policy). RSNs are required by law to negotiate with tribes concerning their participation on the governing boards. American Indian tribes should request, in writing, a seat on the governing board of the RSN in their area and a copy of the letter should be sent to MHD. If an agreement cannot be reached between tribes and the RSN through collaboration, MHD's tribal liaison and IPSS should be asked to facilitate a resolution. It is further recommended that tribes participate in and regularly communicate with, the RSNs' advisory boards.

quality review teams, and ombuds services in order to improve services to American Indian communities.

7. It is a common stereotype that American Indian mental health care programs in the State of Washington do not maintain professional standards, but this is simply not true. American Indian mental health programs in the State of Washington operate with high professional standards. For example, these programs insist that the providers they employ are licensed or certified for their appropriate discipline (e.g. psychiatrists, psychologists, and mid-level professionals). In addition, some programs currently hold national accreditation, and all 22 programs in the State of Washington meet IHS program standards under their 638 contracts. State, federal, and local governmental agencies must recognize that American Indian mental health programs operate with very high professional standards.

8. State and federal laws have generally pre-determined how MHD is to spend and distribute the majority of the funding that supports Washington State's mental health care system. RCW 71.24 requires that majority of these funds are distributed to RSNs via a pre-set distribution formula. However, there is some flexibility as to how MHD and RSNs can spend 100 percent federal mental health block grant and state-only funds; some portions of state-only funds and large portions of 100 percent federal mental health block grant funds can be used to support a wide range of pilot projects, technical assistance, training and educational services (some American Indian mental health programs currently receive portions of these funds from MHD and certain RSNs. Tribal- and urban-based American Indian mental health programs should be proactively approaching and negotiating with MHD and RSNs to access this funding.

9. When a researcher plans to make an American Indian community the subject of a research effort, permission must be obtained from the tribal council prior to initiating the research process. Tribal control of research efforts and associated data is fundamental to tribal self-determination. Tribes should have the opportunity to address the research questions, research methodology, findings of the study, and how the findings of the study will be used and distributed. Tribes should retain at least some, if not total, control of the findings. If it is determined that the research effort will not produce a product (document or data) that is useful to the tribe, the research should not be conducted. Upon completion of a research project, its results must be presented to the tribal council for their use.

10. Federal, state, and local governmental employees planning to interact with tribal communities must respect the autonomy of tribes; this respect includes having at least a rudimentary understanding of the meaning of tribal sovereignty (information and/or training on this subject can be obtained from GOIA, IPSS, or from the tribal community with which the non-tribal employee is

planning to interact). Furthermore, state and county governments must be willing to interact with tribes on a government-to-government basis (based on a framework similar to the one described by the Centennial Accord Agreement of 1989).

11. MHD should explicitly require in their contract terms with RSNs that they interact with federally recognized American Indian tribes on a government-to-government basis (based on a framework similar to the one described by the Centennial Accord Agreement of 1989).

12. Representatives of tribes should interact with state and local governmental employees who represent a particular agency without holding it or its employees accountable for past conflicts that the tribe has had with other state and local governmental agencies.

13. Employees of federal, state, and local governmental agencies should realize that when interacting with tribes, they are doing so in a cross-cultural environment. American Indian and non-Indian people have many cultural and value differences, and tend to utilize different methods of social interaction and interpersonal communication. Indian and non-Indian professionals should understand and respect these differences in order to improve the communication process.

14. Tribes and state or local governmental agencies may wish to enter into a formal written memorandum of understanding as a means of finalizing agreements that are reached through negotiation. The State Interlocal Cooperation Act (RCW 39.34) can be used as a resource for tribes and local or state agencies to establish these formal agreements.

15. Tribal-based mental health programs would greatly benefit from a statewide conference between tribes, the SIHB and N.A.T.I.V.E. Project, and staff representing CMS, IHS, MHD, IPSS, and DASA. Some of the key issues that this conference should focus on include: 1) billing under the MOA; 2) improving access for tribes to the State of Washington's mental health and ADATSA inpatient systems, and how these systems could better service tribes in the future; 3) the need for improved data describing the prevalence of mental health illnesses and dual-diagnosis in clients served by American Indian programs; 4) how MHD and DASA could combine resources to better serve American Indians suffering from dual-diagnosis. Tribal, federal, and state government officials should work together collaboratively to plan such a conference.

16. Tribes need to better familiarize themselves with the Community Mental Health Services Act, Chapter 71.24 of the Revised Code of Washington (RCW), and Chapter 388-865 of the Washington Administrative Code. These laws detail

most aspects of how the public mental health care system operates in the State of Washington.

17. Tribes estimate that an average of 70-90 percent of their clients suffer for co-occurring disorders or a dual-diagnosis of mental health illness, and drug and alcohol addiction. Providers at these programs feel that these high levels of dual-diagnosis can be largely attributed to clients self-medicating. Following what seems to be the beginning of a national trend, the State of Washington should create a seamless system of care to better serve the dually diagnosed. This system should address the disorders these clients suffer from simultaneously, not sequentially. This treatment would require closer collaboration between MHD and DASA, or possibly an integration of some of their programs and facilities. Several tribal-based programs in the State of Washington currently operate a seamless system of care within their chemical dependency, and alcohol and mental health programs.

18. Many tribal-based mental health programs are increasing their revenues by billing under the MOA, and as a result, national accreditation is becoming a more viable option for these programs. CARF and AAAHP offer three-year accreditation for between $3,700 and $5,000 per three-year period. Both of these organizations stated that they have had great success in accrediting American Indian behavioral health programs in the past. Tribes should consider having their mental health programs nationally accredited. By becoming nationally accredited, it will be easier to negotiate with the State of Washington and the RSNs, as well as compete for grant funding.

19. IPAC and/or the AIHC should address the need for a statewide effort to standardize and maintain datasets about the prevalence of mental health problems among American Indian populations. This data, which would need to be compiled and controlled by a tribal organization, is greatly needed for grant writing, program planning, and lobbying.

20. IPAC and/or the AIHC should request funding from IHS to conduct a cost-benefit analysis of building an IHS Hospital in the Pacific Northwest. This hospital should include a psychiatric ward.

21. IPAC and/or the AIHC should address how tribal-based mental health programs can improve their access to the State of Washington's inpatient mental health care system. Although it may not be realistic in today's political environment, several options (all which would require revising of the Community Mental Health Care Services Act, [RCW 71.24]), include: 1) allow tribes to form a single or multiple RSNs among themselves, or with neighboring county governments, 2) require RSNs to coordinate directly with tribes on inpatient placements, removing their contracted providers from the process altogether, 3) require MHD to coordinate directly with tribes on inpatient placements, removing RSNs from

the process altogether, 4) redirect a portion of inpatient funding to create mental health bed space in the four existing Alcohol and Drug Addiction Treatment and Support Act (ADATSA) facilities in the State of Washington that specialize in the treatment of American Indians (this could be the easiest way to improve services to the dually diagnosed). A more realistic option, which would not require revising RCW 71.24, would be to approach CMS with a plan to fund "Evaluation and Treatment" and "Community Hospital Beds" for tribes that are funded with 100 percent federal dollars.

22. There are few issues currently more important to tribal-based mental health care programs than improving access to the inpatient system. A workgroup should be established between tribal, federal, and state officials to more clearly define the current inpatient needs of tribes in the State of Washington and how tribes can achieve fair and equitable access to these services. Attempts should be made to clearly define the quantity of need, estimate approximate annual cost to meet this need, and define what would be culturally competent inpatient services for American Indians. In our research, we determined that estimates of the need of tribes for publicly funded inpatient services varied by quantity and type of services from tribe-to-tribe. Most tribes estimated their need for inpatient placement within the range of one to five cases annually. Four tribes estimated a much higher unmet need, at ten, fifteen, sixteen, and twenty-four cases per year respectively. An annual statewide estimate for the need of tribal-based mental health care programs would be roughly 130-150 cases. These cases could be split evenly (50/50) between youth and adults. Additionally, at least 70 percent of these cases would be dual diagnosed clients. Finally, about 60 percent of these cases would be short-term, crisis stabilization cases.

23. Of the twenty-nine federally recognized tribes in the State of Washington, twenty-two have mental health care programs currently operating (one of which is operated by IHS directly). Eighteen of these tribes have obtained provider numbers for their mental health programs to bill under the MOA. Of these eighteen tribes, only twelve seem to be actively billing. Between January and September of 2001, these programs have billed for approximately $2.5 million in Medicaid reimbursement. Additionally, there are at least four tribes and several Indian organizations that are currently providing some type of billable mental health care services, and yet have not obtained a provider number and are not currently billing. Nine of the ten tribes not currently billing wish to do so in the near future. Tribes and Indian organizations that are not billing should do so in the future (especially those that are currently providing billable services). Tribes that are not billing are missing an excellent opportunity to increase revenues for their programs.

24. At least ten tribes feel that they have the capacity and are interested in having the option of issuing court orders requiring tribal members to undergo mental health care treatment. Of course, to be effective, these orders would have to be

recognized by county and state governments. At least one tribe in the State of Washington has successfully negotiated an agreement of this type with their local county government. Tribes and the State of Washington should collaboratively address this important jurisdiction issue.

25. Almost every tribe in the State of Washington provides some level of support to their tribal members in the application process for Medicaid. With few exceptions, DSHS outreach workers that provide this type of support have been ineffective. The State of Washington should provide funding support to tribes so that they can effectively provide outreach and support to their tribal members in the application process for Medicaid.

26. Traditional healing and cultural activities are critical and integral components of most American Indian mental health care programs. CMS should create mechanisms whereby tribal- and urban-based mental health care programs can be reimbursed on a fee-for-service basis for the work of traditional healers and cultural practitioners.

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Appendix One

MEMORANDUM OF AGREEMENT BETWEEN THE INDIAN HEALTH SERVICE AND THE HEALTH CARE FINANCING ADMINISTRATION

I. Purpose

The purpose of this memorandum of agreement (MOA) is to establish the roles and responsibilities of the Health Care Financing Administration (HCFA) and the Indian Health Service (IHS) in implementing a change in payment policy for Medicaid services provided on or after July 11, 1996, to American Indian and Alaska Native (AI/AN) individuals through health care facilities owned and operated by AI/AN tribes and tribal organizations with funding authorized by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), hereafter "638."

II. Policy

The United States Government has a historical and unique legal relationship with, and resulting responsibility to, AI/AN people. A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage maximum participation of AI/ANs in the planning and management of those services. The health care delivery system for AI/AN tribes with this unique government-togovernment relationship consists of IHS-owned and operated health care facilities, IHS-owned facilities that are operated by AI/AN tribes or tribal organizations under 638 agreements (contracts, grants, or compacts), and facilities owned and operated by tribes or tribal organizations under such agreements.

AI/AN individuals are entitled to equal access to state, local, and Federal programs to which other citizens are entitled. Under the provision of its approved medical assistance plan, the state Medicaid agency is responsible for meeting the cost of services provided therein for all individuals, regardless of race or national origin, who apply and are found eligible. Many IHS and tribally owned health care facilities provide such Medicaid services to AI/AN individuals, and states reimburse the facilities accordingly.

Prior to July 11, 1996, if such services were provided by a health care facility operated by the IHS or by a tribe or tribal organization under a 638 agreement, HCFA interpretation of the controlling statute, section 1905(b) of the Social Security Act (the Act), 42 U.S.C. 1396d, provided the state with 100percent Federal medical assistance percentage (FMAP), or 100-percent Federal reimbursement, only for payments made by the state for services rendered through an IHS-owned or leased facility. If such services were provided through a tribally owned and operated facility, the state received an FMAP of 100 per centum less the state percentage, which, depending on the state, could range from 50-percent to 83-percent of the amount the state paid the facility.

A recent amendment to 638 added a new subsection that affects this payment policy. Upon request of a tribe or tribal organization, new section 105(1) requires the Secretary of Health and Human Services, through the IHS, to enter into a lease with a tribe or tribal organization that holds title to or leasehold or trust interest in a facility used by such tribe or tribal organization for administration and delivery of 638 health care services. An IHS lease of any tribally owned facility in which 638 health services are provided would then make the state entitled to the 100-percent FMAP for services provided through the facility. Without this change in policy, states would have had a strong financial incentive to encourage tribes to request that IHS enter into leases of tribal facilities. These requests could have resulted in the processing and signing of possibly hundreds of mandatory leases.

To address state financing concerns, to encourage tribal self-determination in program operation and facility ownership, and to eliminate the processing of numerous leaseback requests, HCFA reevaluated its original interpretation of section 1905(b). In light of the above amendment to 638 and underlying Federal Indian policy, HCFA concluded that the statutory language in this context permits an interpretation that tribal facilities operating under a 638 agreement are functioning as IHS facilities in performing obligations set forth under that agreement. Thus, as of July 11, 1996, the Secretary approved HCFA's proposal to adopt an interpretation that section 1905(b) allows 100-percent FMAP for Medicaid services furnished to Medicaid eligible AI/ANs by any tribal facility operating under a 638 agreement. This means that the state will be reimbursed for 100 percent of the amount it pays to any 638 facility for services provided to Medicaid eligible AI/ANs only, and services provided to Medicaid eligible non-Indians will continue to be reimbursed at the state's usual FMAP. The IHS has concurred in this new interpretation and in the revised policy.

It is the policy of both the IHS and HCFA to assure quality health care for AI/AN people. Section 1902(a)(9) of the Act requires a state plan for medical assistance to provide that the state agency shall be responsible for establishing and maintaining health standards for private or public institutions in which Medicaid beneficiaries receive care or services. Section 1911 of the Act provides that an IHSowned or leased facility, whether operated by the IHS or a tribe or tribal organization, shall be eligible for reimbursement for Medicaid services provided under a state plan so long as it meets all the conditions and requirements generally applicable to such facilities under the Medicaid statute. IHS and tribes have worked towards meeting strong quality of care standards including, where appropriate, accreditation of IHS and tribal facilities by recognized accreditation bodies. For Medicaid reimbursement in the past, IHS-owned or leased facilities were certified by HCFA as meeting standards of care, and tribally owned health care facilities were certified by the states, where required. In implementing 100-percent FMAP for tribal 638 facilities, HCFA and IHS acknowledge that these facilities must meet all conditions and requirements applicable under the Medicaid statute and will encourage either state certification or accreditation by a recognized accreditation body, such as JCAHO, for all tribal facilities that participate in their programs.

Current Medicaid regulations require a state plan to provide that an IHS facility meeting state requirements for Medicaid participation must be accepted on the same basis as any other qualified provider. However, when state licensure is normally required, the regulations provide that the IHS facility need not obtain such a license but must meet all applicable standards for licensure. With the new interpretation that tribally owned and operated 638 facilities are "IHS facilities," such 638 facilities must meet all applicable standards for licensure but need not obtain a state license.

Prior to July 11, 1996, many 638 facilities participated in state Medicaid programs as FQHCs or other types of providers under the state plan. In implementing 100-percent FMAP for 638 facilities, a tribally operated facility may: (1) continue to operate as an FQHC under the state plan and receive the FQHC reimbursement rate; (2) if it so qualifies, operate as any other provider type recognized under the state plan and receive that respective reimbursement rate; or (3) choose to be designated as an IHS provider. If the facility chooses to be designated as an IHS provider for purposes of the payment policy and this MOA, it will receive the IHS payment rate for services to AI/ANs; however, at state option, the IHS payment rate may not be available for services to non-Indian Medicaid beneficiaries as the state will not receive 100-percent FMAP for services to non-Indians.

III. Implementation

A. To assist HCFA in the implementation of this revised policy, IHS shall, within the limits of its authorities and resources:

1. Negotiate with the tribes and tribal organizations to include in any 638 agreement tribal quality of care standards necessary to meet state licensure, accreditation, or certification requirements, if any (which may be met through accreditation by a recognized accreditation body, such as JCAHO).

2. Develop and maintain a list of IHS-operated facilities and Indian health care facilities operating under a 638 agreement, including the following information: (1) whether each such facility is IHS-owned or leased or tribally owned; (2) the name and location of each such facility; (3) the type of each such facility; (4) whether each such facility is operated under its own Medicaid provider number and, if so, state that number; and (5) each such facility's accreditation body and status.

3. Provide HCFA with the list in A2 at least once per fiscal year.

4. Inform all facilities identified in A2 above that valid Medicaid claims should include all information the state requires from any similar facilities serving the general Medicaid population and receiving reimbursement under the state plan.

5. Continue to provide technical assistance to tribes and tribal organizations to maintain and maintain tribal quality of care standards necessary to meet state licensure, accreditation, or certification requirements.

6. Promptly share with HCFA any problems arising from this policy change.

B. HCFA shall, within the limits of its authorities and resources:

1. Revise its payment policy to provide 100-percent FMAP with respect to amounts expended by the state for Medicaid services to eligible AUANs received through tribally owned facilities operating under a 638 agreement, as identified in the IHS list in A2 above, as well as for Medicaid services received through IHS-owned or leased facilities.

2. Provide technical assistance to states and AI/AN tribes and tribal organizations to assure smooth implementation of this new payment policy.

3. Provide assistance to the tribes/tribal organizations and states in developing the method for reimbursement of facilities identified in A2 above with the understanding that each such tribe/tribal organization shall have the option to choose among the provider types for which it qualifies that are recognized under the state plan.

4. Upon receipt of the list in A2 from IHS, provide the states with that list at least once per fiscal year.

5. Provide technical assistance to facilitate the tribes' and tribal organizations' attainment and maintenance of tribal quality of care standards necessary to meet state licensure, accreditation, or certification requirements.

6. Promptly share with IHS any problems arising from this policy change.

C. Nothing contained herein shall be construed as abrogating or limiting the rights of AI/ANs presently established under any treaty, statute, or regulation.

IV. Effective Dates

The payment policy change specified in this MOA is effective for services provided on or after July 11, 1996. Agency responsibilities set forth in this MOA shall become effective beginning on the date of the day after the latest signature date below.

_____/S/_____12/19/96	_____/S/_____12/19/96
Michael H. Trujillo, MD	Bruce C. Vladeck
Director	Administrator
Indian Health Service	Health Care Financing Administration

Appendix Two

Chapter 71.24 RCW
COMMUNITY MENTAL HEALTH SERVICES ACT

SECTIONS

71.24.900 Effective date -- 1967 ex.s. c 111.

71.24.901 Severability -- 1982 c 204.

71.24.902 Construction.

NOTES:

Reviser's note: The department of social and health services filed an emergency order, WSR 89-20-030, effective October 1, 1989, establishing rules for the recognition and certification of regional support networks. A final order was filed on January 24, 1990, effective January 25, 1990.

Comprehensive community health centers: Chapter 70.10 RCW.Funding: RCW 43.79.201 and 79.01.007.

RCW 71.24.011
Short title.

This chapter may be known and cited as the community mental health services act.

[1982 c 204 § 1.]

RCW 71.24.015
Legislative intent and policy.

It is the intent of the legislature to establish a community mental health program which shall help people experiencing mental illness to retain a respected and productive position in the community. This will be accomplished through programs which provide for:

(1) Access to mental health services for adults of the state who are acutely mentally ill, chronically mentally ill, or seriously disturbed and children of the state who are acutely mentally ill, severely emotionally disturbed, or seriously disturbed, which services recognize the special needs of underserved populations, including minorities, children, the elderly, disabled, and low-income persons. Access to mental health services shall not be limited by a person's history of confinement in a state, federal, or local correctional facility. It is also the purpose of this chapter to promote the early identification of mentally ill children and to ensure that they receive the mental health care and treatment which is appropriate to their developmental level. This care should improve home, school, and community functioning, maintain children in a safe and nurturing home environment, and should enable treatment decisions to be made in response to clinical needs in accordance with sound professional judgment while also recognizing parents' rights to participate in treatment decisions for their children;

(2) Accountability of services through state-wide standards for monitoring and reporting of information;

(3) Minimum service delivery standards;

(4) Priorities for the use of available resources for the care of the mentally ill;

(5) Coordination of services within the department, including those divisions within the department that provide services to children, between the department and the office of the superintendent of public instruction, and among state mental hospitals, county authorities, community mental health services, and other support services, which shall to the maximum extent feasible also include the families of the mentally ill, and other service providers; and

(6) Coordination of services aimed at reducing duplication in service delivery and promoting complementary services among all entities that provide mental health services to adults and children.

It is the policy of the state to encourage the provision of a full range of treatment and rehabilitation services in the state for mental disorders. The legislature intends to encourage the development of county-based and county-managed mental health services with adequate local flexibility to assure eligible people in need of care access to the least-restrictive treatment alternative appropriate to their needs, and the availability of treatment components to assure continuity of care. To this end, counties are encouraged to enter into joint operating agreements with other counties to form regional systems of care which integrate planning, administration, and service delivery duties assigned to counties under chapters 71.05 and 71.24 RCW to consolidate administration, reduce administrative layering, and reduce administrative costs.

It is further the intent of the legislature to integrate the provision of services to provide continuity of care through all phases of treatment. To this end the legislature intends to promote active engagement with mentally ill persons and collaboration between families and service providers.

[1999 c 214 § 7; 1991 c 306 § 1; 1989 c 205 § 1; 1986 c 274 § 1; 1982 c 204 § 2.]

NOTES:

Intent -- Effective date -- 1999 c 214: See notes following RCW 72.09.370.

Conflict with federal requirements -- 1991 c 306: "If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. The rules under this act shall meet federal requirements that are a necessary condition to the receipt of federal funds by the state.

However, if any part of this act conflicts with such federal requirements, the state appropriation for mental health services provided to children whose mental disorders are discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program shall be provided through the division of medical assistance and no state funds appropriated to the division of mental health shall be expended or transferred for this purpose." [1991 c 306 § 7.]

Effective date -- 1986 c 274 §§ 1, 2, 3, 5, and 9: "Sections 1, 2, 3, 5, and 9 of this act shall take effect on July 1, 1987." [1986 c 274 § 11.]

RCW 71.24.025
Definitions.

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Acutely mentally ill" means a condition which is limited to a short-term severe crisis episode of:

(a) A mental disorder as defined in RCW 71.05.020 or, in the case of a child, as defined in RCW 71.34.020;

(b) Being gravely disabled as defined in RCW 71.05.020 or, in the case of a child, a gravely disabled minor as defined in RCW 71.34.020; or

(c) Presenting a likelihood of serious harm as defined in RCW 71.05.020 or, in the case of a child, as defined in RCW 71.34.020.

(2) "Available resources" means funds appropriated for the purpose of providing community mental health programs under RCW 71.24.045, federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated under this chapter or chapter 71.05 RCW by the legislature during any biennium

for the purpose of providing residential services, resource management services, community support services, and other mental health services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals, except as negotiated according to RCW 71.24.300(1)(d).

(3) "Child" means a person under the age of eighteen years.

(4) "Chronically mentally ill adult" means an adult who has a mental disorder and meets at least one of the following criteria:

(a) Has undergone two or more episodes of hospital care for a mental disorder within the preceding two years; or

(b) Has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding year; or

(c) Has been unable to engage in any substantial gainful activity by reason of any mental disorder which has lasted for a continuous period of not less than twelve months. "Substantial gainful activity" shall be defined by the department by rule consistent with Public Law 92-603, as amended.

(5) "Community mental health program" means all mental health services, activities, or programs using available resources.

(6) "Community mental health service delivery system" means public or private agencies that provide services specifically to persons with mental disorders as defined under RCW 71.05.020 and receive funding from public sources.

(7) "Community support services" means services authorized, planned, and coordinated through resource management services including, at least, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week, prescreening determinations for mentally ill persons being considered for placement in nursing homes as required by federal law, screening for patients being considered for admission to residential services, diagnosis and treatment for acutely mentally ill and severely emotionally disturbed children discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program, investigation, legal, and other nonresidential services under chapter 71.05 RCW, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, other services determined by regional support networks, and maintenance of a patient tracking system for chronically mentally ill adults and severely emotionally disturbed children.

(8) "County authority" means the board of county commissioners, county council, or county executive having authority to establish a community mental health program, or two or more of the county authorities specified in this subsection which have entered into an agreement to provide a community mental health program.

(9) "Department" means the department of social and health services.

(10) "Licensed service provider" means an entity licensed according to this chapter or chapter 71.05 RCW that meets state minimum standards or individuals licensed under chapter 18.57, 18.71, 18.83, or 18.79 RCW, as it applies to registered nurses and advanced registered nurse practitioners.

(11) "Mental health services" means all services provided by regional support networks and other services provided by the state for the mentally ill.

(12) "Mentally ill persons" and "the mentally ill" mean persons and conditions defined in subsections (1), (4), (17), and (18) of this section.

(13) "Regional support network" means a county authority or group of county authorities recognized by the secretary that enter into joint operating agreements to contract with the secretary pursuant to this chapter.

(14) "Residential services" means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for acutely mentally ill persons, chronically mentally ill adults, severely emotionally disturbed children, or seriously disturbed adults determined by the regional support network to be at risk of becoming acutely or chronically mentally ill. The services shall include at least evaluation and treatment services as defined in chapter 71.05 RCW, acute crisis respite care, long-term adaptive and rehabilitative care, and supervised and supported living services, and shall also include any residential services developed to service mentally ill persons in nursing homes. Residential services for children in out-of-home placements related to their mental disorder shall not include the costs of food and shelter, except for children's long-term residential facilities existing prior to January 1, 1991.

(15) "Resource management services" mean the planning, coordination, and authorization of residential services and community support services administered pursuant to an individual service plan for: (a) Acutely mentally ill adults and children; (b) chronically mentally ill adults; (c) severely emotionally disturbed children; or (d) seriously disturbed adults determined solely by a regional support network to be at risk of becoming acutely or chronically mentally ill. Such planning, coordination, and authorization shall include mental health screening for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program. Resource management services include seven day a week, twenty-four hour a day availability of information regarding mentally ill adults' and children's enrollment in services and their individual service plan to county-designated mental health professionals, evaluation and treatment facilities, and others as determined by the regional support network.

(16) "Secretary" means the secretary of social and health services.

(17) "Seriously disturbed person" means a person who:

(a) Is gravely disabled or presents a likelihood of serious harm to himself or herself or others, or to the property of others, as a result of a mental disorder as defined in chapter 71.05 RCW;

(b) Has been on conditional release status, or under a less restrictive alternative order, at some time during the preceding two years from an evaluation and treatment facility or a state mental health hospital;

(c) Has a mental disorder which causes major impairment in several areas of daily living;

(d) Exhibits suicidal preoccupation or attempts; or

(e) Is a child diagnosed by a mental health professional, as defined in chapter 71.34 RCW, as experiencing a mental disorder which is clearly interfering with the child's functioning in family or school or with peers or is clearly interfering with the child's personality development and learning.

(18) "Severely emotionally disturbed child" means a child who has been determined by the regional support network to be experiencing a mental disorder as defined in chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers and who meets at least one of the following criteria:

(a) Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years;

(b) Has undergone involuntary treatment under chapter 71.34 RCW within the last two years;

(c) Is currently served by at least one of the following child-serving systems: Juvenile justice, child-protection/welfare, special education, or developmental disabilities;

(d) Is at risk of escalating maladjustment due to:

(i) Chronic family dysfunction involving a mentally ill or inadequate caretaker;

(ii) Changes in custodial adult;

(iii) Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient, residential treatment, group or foster home, or a correctional facility;

(iv) Subject to repeated physical abuse or neglect;

(v) Drug or alcohol abuse; or

(vi) Homelessness.

(19) "State minimum standards" means minimum requirements established by rules adopted by the secretary and necessary to implement this chapter for: (a) Delivery of mental health services; (b) licensed service providers for the provision of mental health services; (c) residential services; and (d) community support services and resource management services.

(20) "Tribal authority," for the purposes of this section and RCW 71.24.300 only, means: The federally recognized Indian tribes and the major Indian organizations recognized by the secretary insofar as these organizations do not have a financial relationship with any regional support network that would present a conflict of interest.

[1999 c 10 § 2; 1997 c 112 § 38; 1995 c 96 § 4. Prior: 1994 sp.s. c 9 § 748; 1994 c 204 § 1; 1991 c 306 § 2; 1989 c 205 § 2; 1986 c 274 § 2; 1982 c 204 § 3.]

NOTES:

Purpose -- Intent -- 1999 c 10: "The purpose of this act is to eliminate dates and provisions in chapter 71.24 RCW which are no longer needed. The legislature does not intend this act to make, and no provision of this act shall be construed as, a substantive change in the service delivery system or funding of the community mental health services law." [1999 c 10 § 1.]

Alphabetization of section -- 1999 c 10 § 2: "The code reviser shall alphabetize the definitions in RCW 71.24.025 and correct any cross-references." [1999 c 10 § 14.]

Effective date -- 1995 c 96: See note following RCW 71.24.400.

Severability -- Headings and captions not law -- Effective date -- 1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

Conflict with federal requirements -- 1991 c 306: See note following RCW 71.24.015.

Effective date -- 1986 c 274 §§ 1, 2, 3, 5, and 9: See note following RCW 71.24.015.

RCW 71.24.030
Grants to counties for programs.

The secretary is authorized to make grants to counties or combinations of counties in the establishment and operation of community mental health programs.

[1999 c 10 § 3; 1982 c 204 § 6; 1973 1st ex.s. c 155 § 5; 1972 ex.s. c 122 § 30; 1971 ex.s. c 304 § 7; 1967 ex.s. c 111 § 3.]

NOTES:

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

Effective date -- 1972 ex.s. c 122: See note following RCW 70.96A.010.

RCW 71.24.035
Secretary's powers and duties as state mental health authority, county authority.

(1) The department is designated as the state mental health authority.

(2) The secretary may provide for public, client, and licensed service provider participation in developing the state mental health program.

(3) The secretary shall provide for participation in developing the state mental health program for children and other underserved populations, by including representatives on any committee established to provide oversight to the state mental health program.

(4) The secretary shall be designated as the county authority if a county fails to meet state minimum standards or refuses to exercise responsibilities under RCW 71.24.045.

(5) The secretary shall:

(a) Develop a biennial state mental health program that incorporates county biennial needs assessments and county mental health service plans and state services for mentally ill adults and children. The secretary may also develop a six-year state mental health plan;

(b) Assure that any county community mental health program provides access to treatment for the county's residents in the following order of priority: (i) The acutely mentally ill; (ii) chronically mentally ill adults and severely emotionally disturbed children; and (iii) the seriously disturbed. Such programs shall provide:

(A) Outpatient services;

(B) Emergency care services for twenty-four hours per day;

(C) Day treatment for mentally ill persons which includes training in basic living and social skills, supported work, vocational rehabilitation, and day activities. Such services may include therapeutic treatment. In the case of a child, day treatment includes age-appropriate basic living and social skills, educational and prevocational services, day activities, and therapeutic treatment;

(D) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of admission;

(E) Employment services, which may include supported employment, transitional work, placement in competitive employment, and other work-related services, that result in mentally ill persons becoming engaged in

meaningful and gainful full or part-time work. Other sources of funding such as the division of vocational rehabilitation may be utilized by the secretary to maximize federal funding and provide for integration of services;

(F) Consultation and education services; and

(G) Community support services;

(c) Develop and adopt rules establishing state minimum standards for the delivery of mental health services pursuant to RCW 71.24.037 including, but not limited to:

(i) Licensed service providers;

(ii) Regional support networks; and

(iii) Residential and inpatient services, evaluation and treatment services and facilities under chapter 71.05 RCW, resource management services, and community support services;

(d) Assure that the special needs of minorities, the elderly, disabled, children, and low-income persons are met within the priorities established in this section;

(e) Establish a standard contract or contracts, consistent with state minimum standards, which shall be used by the counties;

(f) Establish, to the extent possible, a standardized auditing procedure which minimizes paperwork requirements of county authorities and licensed service providers;

(g) Develop and maintain an information system to be used by the state, counties, and regional support networks that includes a tracking method which allows the department and regional support networks to identify mental health clients' participation in any mental health service or public program on an immediate basis. The information system shall not include individual patient's case history files. Confidentiality of client information and records shall be maintained as provided in this chapter and in RCW 71.05.390, 71.05.400, 71.05.410, 71.05.420, 71.05.430, and 71.05.440;

(h) License service providers who meet state minimum standards;

(i) Certify regional support networks that meet state minimum standards;

(j) Periodically inspect certified regional support networks and licensed service providers at reasonable times and in a reasonable manner;

(k) Fix fees to be paid by evaluation and treatment centers to the secretary for the required inspections;

(l) Monitor and audit counties, regional support networks, and licensed service providers as needed to assure compliance with contractual agreements authorized by this chapter; and

(m) Adopt such rules as are necessary to implement the department's responsibilities under this chapter.

(6) The secretary shall use available resources only for regional support networks.

(7) Each certified regional support network and licensed service provider shall file with the secretary, on request, such data, statistics, schedules, and information as the secretary reasonably requires. A certified regional support network or licensed service provider which, without good cause, fails to furnish any data, statistics, schedules, or

information as requested, or files fraudulent reports thereof, may have its certification or license revoked or suspended.

(8) The secretary may suspend, revoke, limit, or restrict a certification or license, or refuse to grant a certification or license for failure to conform to: (a) The law; (b) applicable rules and regulations; (c) applicable standards; or (d) state minimum standards.

(9) The superior court may restrain any regional support network or service provider from operating without certification or a license or any other violation of this section. The court may also review, pursuant to procedures contained in chapter 34.05 RCW, any denial, suspension, limitation, restriction, or revocation of certification or license, and grant other relief required to enforce the provisions of this chapter.

(10) Upon petition by the secretary, and after hearing held upon reasonable notice to the facility, the superior court may issue a warrant to an officer or employee of the secretary authorizing him or her to enter at reasonable times, and examine the records, books, and accounts of any regional support network or service provider refusing to consent to inspection or examination by the authority.

(11) Notwithstanding the existence or pursuit of any other remedy, the secretary may file an action for an injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, or operation of a regional support network or service provider without certification or a license under this chapter.

(12) The standards for certification of evaluation and treatment facilities shall include standards relating to maintenance of good physical and mental health and other services to be afforded persons pursuant to this chapter and chapters 71.05 and 71.34 RCW, and shall otherwise assure the effectuation of the purposes of these chapters.

(13)(a) The department, in consultation with affected parties, shall establish a distribution formula that reflects county needs assessments based on the number of persons who are acutely mentally ill, chronically mentally ill, severely emotionally disturbed children, and seriously disturbed. The formula shall take into consideration the impact on counties of demographic factors in counties which result in concentrations of priority populations as set forth in subsection (5)(b) of this section. These factors shall include the population concentrations resulting from commitments under chapters 71.05 and 71.34 RCW to state psychiatric hospitals, as well as concentration in urban areas, at border crossings at state boundaries, and other significant demographic and workload factors.

(b) The formula shall also include a projection of the funding allocations that will result for each county, which specifies allocations according to priority populations, including the allocation for services to children and other underserved populations.

(14) The secretary shall assume all duties assigned to the nonparticipating counties under chapters 71.05, 71.34, and 71.24 RCW. Such responsibilities shall include those which would have been assigned to the nonparticipating counties under regional support networks.

The regional support networks, or the secretary's assumption of all responsibilities under chapters 71.05, 71.34, and 71.24 RCW, shall be included in all state and federal plans affecting the state mental health program including at least those required by this chapter, the medicaid program, and P.L. 99-660. Nothing in these plans shall be inconsistent with the intent and requirements of this chapter.

(15) The secretary shall:

(a) Disburse funds for the regional support networks within sixty days of approval of the biennial contract. The department must either approve or reject the biennial contract within sixty days of receipt.

(b) Enter into biennial contracts with regional support networks. The contracts shall be consistent with available resources. No contract shall be approved that does not include progress toward meeting the goals of this chapter by taking responsibility for: (i) Short-term commitments; (ii) residential care; and (iii) emergency response systems.

(c) Allocate one hundred percent of available resources to the regional support networks in accordance with subsection (13) of this section.

(d) Notify regional support networks of their allocation of available resources at least sixty days prior to the start of a new biennial contract period.

(e) Deny funding allocations to regional support networks based solely upon formal findings of noncompliance with the terms of the regional support network's contract with the department. Written notice and at least thirty days for corrective action must precede any such action. In such cases, regional support networks shall have full rights to appeal under chapter 34.05 RCW.

(f) Identify in its departmental biennial operating and capital budget requests the funds requested by regional support networks to implement their responsibilities under this chapter.

(16) The department, in cooperation with the state congressional delegation, shall actively seek waivers of federal requirements and such modifications of federal regulations as are necessary to allow federal medicaid reimbursement for services provided by free-standing evaluation and treatment facilities certified under chapter 71.05 RCW. The department shall periodically report its efforts to the health care and corrections committee of the senate and the human services committee of the house of representatives.

(17) The secretary shall establish a task force to examine the recruitment, training, and compensation of qualified mental health professionals in the community, which shall include the advantages and disadvantages of establishing a training academy, loan forgiveness program, or educational stipends offered in exchange for commitments of employment in mental health.

[1999 c 10 § 4; 1998 c 245 § 137. Prior: 1991 c 306 § 3; 1991 c 262 § 1; 1991 c 29 § 1; 1990 1st ex.s. c 8 § 1; 1989 c 205 § 3; 1987 c 105 § 1; 1986 c 274 § 3; 1982 c 204 § 4.]

NOTES:

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

Conflict with federal requirements -- 1991 c 306: See note following RCW 71.24.015.

Effective date -- 1987 c 105: "This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect July 1, 1987." [1987 c 105 § 2.]

Effective date -- 1986 c 274 §§ 1, 2, 3, 5, and 9: See note following RCW 71.24.015.

RCW 71.24.037
Licensed service providers, residential services, community support services -- Minimum standards.

(1) The secretary shall by rule establish state minimum standards for licensed service providers and services.

(2) Minimum standards for licensed service providers shall, at a minimum, establish: Qualifications for staff providing services directly to mentally ill persons, the intended result of each service, and the rights and responsibilities of persons receiving mental health services pursuant to this chapter.

(3) Minimum standards for residential services shall be based on clients' functional abilities and not solely on their diagnoses, limited to health and safety, staff qualifications, and program outcomes. Minimum standards for residential services shall be developed in collaboration with consumers, families, counties, regulators, and residential providers serving the mentally ill. The minimum standards shall encourage the development of broad-range residential programs, including integrated housing and cross-systems programs where appropriate, and shall not unnecessarily restrict programming flexibility.

(4) Minimum standards for community support services and resource management services shall include at least qualifications for resource management services, client tracking systems, and the transfer of patient information between service providers.

[1999 c 10 § 5.]

NOTES:

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

RCW 71.24.045
County authority powers and duties.

The county authority shall:

(1) Contract as needed with licensed service providers. The county authority may, in the absence of a licensed service provider entity, become a licensed service provider entity pursuant to minimum standards required for licensing by the department for the purpose of providing services not available from licensed service providers;

(2) Operate as a licensed service provider if it deems that doing so is more efficient and cost effective than contracting for services. When doing so, the county authority shall comply with rules promulgated by the secretary that shall provide measurements to determine when a county provided service is more efficient and cost effective;

(3) Monitor and perform biennial fiscal audits of licensed service providers who have contracted with the county to provide services required by this chapter. The monitoring and audits shall be performed by means of a formal process which insures that the licensed service providers and professionals designated in this subsection meet the terms of their contracts, including the minimum standards of service delivery as established by the department;

(4) Assure that the special needs of minorities, the elderly, disabled, children, and low-income persons are met within the priorities established in this chapter;

(5) Maintain patient tracking information in a central location as required for resource management services;

(6) Use not more than two percent of state-appropriated community mental health funds, which shall not include federal funds, to administer community mental health programs under RCW 71.24.155: PROVIDED, That county authorities serving a county or combination of counties whose population is one hundred twenty-five thousand or more may be entitled to sufficient state-appropriated community mental health funds to employ up to one full-time employee or the equivalent thereof in addition to the two percent limit established in this subsection when such employee is providing staff services to a county mental health advisory board;

(7) Coordinate services for individuals who have received services through the community mental health system and who become patients at a state mental hospital.

[1992 c 230 § 5. Prior: 1991 c 363 § 147; 1991 c 306 § 5; 1991 c 29 § 2; 1989 c 205 § 4; 1986 c 274 § 5; 1982 c 204 § 5.]

NOTES:

Effective date -- 1992 c 230 § 5: "Section 5 of this act shall take effect July 1, 1995." [1992 c 230 § 8.]

Intent -- 1992 c 230: See note following RCW 72.23.025.

Purpose -- Captions not law -- 1991 c 363: See notes following RCW 2.32.180.

Conflict with federal requirements -- 1991 c 306: See note following RCW 71.24.015.

Effective date -- 1986 c 274 §§ 1, 2, 3, 5, and 9: See note following RCW 71.24.015.

RCW 71.24.049
Identification by county authority -- Children's mental health services.

By January 1st of each odd-numbered year, the county authority shall identify: (1) The number of children in each priority group, as defined by this chapter, who are receiving mental health services funded in part or in whole under this chapter, (2) the amount of funds under this chapter used for children's mental health services, (3) an estimate of the number of unserved children in each priority group, and (4) the estimated cost of serving these additional children and their families.

[1999 c 10 § 6; 1986 c 274 § 6.]

NOTES:

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

RCW 71.24.100
Joint agreements of county authorities -- Required provisions.

Any agreement between two or more county authorities for the establishment of a community mental health program shall provide:

(1) That each county shall bear a share of the cost of mental health services; and

(2) That the treasurer of one participating county shall be the custodian of funds made available for the purposes of such mental health services, and that the treasurer may make payments from such funds upon audit by the appropriate auditing officer of the county for which he is treasurer.

[1982 c 204 § 7; 1967 ex.s. c 111 § 10.]

RCW 71.24.110
Joint agreements of county authorities -- Permissive provisions.

An agreement for the establishment of a community mental health program under RCW 71.24.100 may also provide:

(1) For the joint supervision or operation of services and facilities, or for the supervision or operation of service and facilities by one participating county under contract for the other participating counties; and

(2) For such other matters as are necessary or proper to effectuate the purposes of this chapter.

[1999 c 10 § 7; 1982 c 204 § 8; 1967 ex.s. c 111 § 11.]

NOTES:

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

RCW 71.24.155
Grants to counties -- Accounting.

Grants shall be made by the department to counties for community mental health programs totaling not less than ninety-five percent of available resources. The department may use up to forty percent of the remaining five percent to provide community demonstration projects, including early intervention or primary prevention programs for children, and the remainder shall be for emergency needs and technical assistance under this chapter.

[1987 c 505 § 65; 1986 c 274 § 9; 1982 c 204 § 9.]

NOTES:

Effective date -- 1986 c 274 §§ 1, 2, 3, 5, and 9: See note following RCW 71.24.015.

RCW 71.24.160
Proof as to uses made of state funds.

The county authority shall make satisfactory showing to the secretary that state funds shall in no case be used to replace local funds from any source being used to finance mental health services prior to January 1, 1990.

[1989 c 205 § 7; 1982 c 204 § 10; 1967 ex.s. c 111 § 16.]

RCW 71.24.200
Expenditures of county funds subject to county fiscal laws.

Expenditures of county funds under this chapter shall be subject to the provisions of chapter 36.40 RCW and other statutes relating to expenditures by counties.

[1967 ex.s. c 111 § 20.]

RCW 71.24.215
Clients to be charged for services.

Clients receiving mental health services funded by available resources shall be charged a fee under sliding-scale fee schedules, based on ability to pay, approved by the department. Fees shall not exceed the actual cost of care.

[1982 c 204 § 11.]

RCW 71.24.220
Reimbursement may be withheld for noncompliance with chapter or related rules.

The secretary may withhold state grants in whole or in part for any community mental health program in the event of a failure to comply with this chapter or the related rules adopted by the department.

[1999 c 10 § 8; 1982 c 204 § 12; 1967 ex.s. c 111 § 22.]

NOTES:

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

RCW 71.24.240
County program plans to be approved by secretary prior to submittal to federal agency.

In order to establish eligibility for funding under this chapter, any county or counties seeking to obtain federal funds for the support of any aspect of a community mental health program as defined in this chapter shall submit program plans to the secretary for prior review and approval before such plans are submitted to any federal agency.

[1982 c 204 § 13; 1967 ex.s. c 111 § 24.]

RCW 71.24.250
County authority may accept and expend gifts and grants.

The county authority may accept and expend gifts and grants received from private, county, state, and federal sources.

[1982 c 204 § 14; 1967 ex.s. c 111 § 25.]

RCW 71.24.260
Waiver of postgraduate educational requirements.

The department shall waive postgraduate educational requirements applicable to mental health professionals under this chapter for those persons who have a bachelor's degree and on June 11, 1986:

(1) Are employed by an agency subject to licensure under this chapter, the community mental health services act, in a capacity involving the treatment of mental illness; and

(2) Have at least ten years of full-time experience in the treatment of mental illness.

[1986 c 274 § 10.]

RCW 71.24.300
Regional support networks -- Roles and responsibilities.

A county authority or a group of county authorities whose combined population is no less than forty thousand may enter into a joint operating agreement to form a regional support network. Upon the request of a tribal authority or authorities within a regional support network the joint operating agreement or the county authority shall allow for the inclusion of the tribal authority to be represented as a party to the regional support network. The roles and responsibilities of the county and tribal authorities shall be determined by the terms of that agreement including a determination of membership on the governing board and advisory committees, the number of tribal representatives to be party to the agreement, and the provisions of law and shall assure the provision of culturally competent services to the tribes served. The state mental health authority may not determine the roles and responsibilities of county authorities as to each other under regional support networks by rule, except to assure that all duties required of regional support networks are assigned and that a single authority has final responsibility for all available resources and performance under the regional support network's contract with the secretary.

(1) Regional support networks shall submit an overall six-year operating and capital plan, timeline, and budget and submit progress reports and an updated two-year plan biennially thereafter, to assume within available resources all of the following duties:

(a) Administer and provide for the availability of all resource management services, residential services, and community support services.

(b) Administer and provide for the availability of all investigation, transportation, court-related, and other services provided by the state or counties pursuant to chapter 71.05 RCW.

(c) Provide within the boundaries of each regional support network evaluation and treatment services for at least eighty-five percent of persons detained or committed for periods up to seventeen days according to chapter 71.05 RCW. Regional support networks with populations of less than one hundred fifty thousand may contract to purchase evaluation and treatment services from other networks. Insofar as the original intent of serving persons in the community is maintained, the secretary is authorized to approve exceptions on a case-by-case basis to the requirement to provide evaluation and treatment services within the boundaries of each regional support network. Such exceptions are limited to contracts with neighboring or contiguous regions.

(d) Administer a portion of funds appropriated by the legislature to house mentally ill persons in state institutions from counties within the boundaries of any regional support network, with the exception of persons currently confined at, or under the supervision of, a state mental hospital pursuant to chapter 10.77 RCW, and provide for the care of all persons needing evaluation and treatment services for periods up to seventeen days according to chapter 71.05 RCW in appropriate residential services, which may include state institutions. The regional support networks shall reimburse the state for use of state institutions at a rate equal to that assumed by the legislature when appropriating funds for such care at state institutions during the biennium when reimbursement occurs. The duty of a state hospital to accept persons for evaluation and treatment under chapter 71.05 RCW is limited by the responsibilities assigned to regional support networks under this section.

(e) Administer and provide for the availability of all other mental health services, which shall include patient counseling, day treatment, consultation, education services, employment services as defined in RCW 71.24.035, and mental health services to children as provided in this chapter.

(f) Establish standards and procedures for reviewing individual service plans and determining when that person may be discharged from resource management services.

(2) Regional support networks shall assume all duties assigned to county authorities by this chapter and chapter 71.05 RCW.

(3) A regional support network may request that any state-owned land, building, facility, or other capital asset which was ever purchased, deeded, given, or placed in trust for the care of the mentally ill and which is within the boundaries of a regional support network be made available to support the operations of the regional support network. State agencies managing such capital assets shall give first priority to requests for their use pursuant to this chapter.

(4) Each regional support network shall appoint a mental health advisory board which shall review and provide comments on plans and policies developed under this chapter. The composition of the board shall be broadly representative of the demographic character of the region and the mentally ill persons served therein. Length of terms of board members shall be determined by the regional support network.

(5) Regional support networks shall assume all duties specified in their plans and joint operating agreements through biennial contractual agreements with the secretary. Such contracts may include agreements to provide periods of stable community living and work or other day activities for specific chronically mentally ill persons who have completed commitments at state hospitals on ninety-day or one hundred eighty-day civil commitments or who have been residents at state hospitals for no less than one hundred eighty days within the previous year. Periods of stable community living may involve acute care in local evaluation and treatment facilities but may not involve use of state hospitals.

(6) Counties or groups of counties participating in a regional support network are not subject to RCW 71.24.045(6).

(7) As part of each biennial plan, each regional support network shall establish and submit to the state, procedures and agreements to assure access to sufficient additional local evaluation and treatment facilities to meet the requirements of this chapter while reducing short-term admissions to state hospitals. These shall be commitments to construct and operate, or contract for the operation of, freestanding evaluation and treatment facilities or agreements with local evaluation and treatment facilities which shall include (a) required admission and treatment for short-term inpatient care for any person enrolled in community support or residential services, (b) discharge planning procedures, (c) limitations on admissions or transfers to state hospitals, (d) adequate psychiatric supervision, (e) prospective payment methods, and (f) contractual assurances regarding referrals to local evaluation and treatment facilities from regional support networks.

(8) Regional support networks may receive technical assistance from the housing trust fund and may identify and submit projects for housing and housing support services to the housing trust fund established under chapter 43.185 RCW. Projects identified or submitted under this subsection must be fully integrated with the regional support network six-year operating and capital plan, timeline, and budget required by subsection (1) of this section.

[1999 c 214 § 8; 1999 c 10 § 9; 1994 c 204 § 2; 1992 c 230 § 6. Prior: 1991 c 295 § 3; 1991 c 262 § 2; 1991 c 29 § 3; 1989 c 205 § 5.]

NOTES:

Reviser's note: This section was amended by 1999 c 10 § 9 and by 1999 c 214 § 8, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Intent -- Effective date -- 1999 c 214: See notes following RCW 72.09.370.

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

Intent -- 1992 c 230: See note following RCW 72.23.025.

Evaluation of transition to regional systems -- 1989 c 205: See note following RCW 71.24.015.

RCW 71.24.310
Implementation of chapters 71.05 and 71.24 RCW through regional support networks.

The legislature finds that administration of chapter 71.05 RCW and this chapter can be most efficiently and effectively implemented as part of the regional support network defined in RCW 71.24.025. For this reason, the legislature intends that any enhanced program funding for implementation of chapter 71.05 RCW or this chapter, except for funds allocated for implementation of mandatory state-wide programs as required by federal statute, be made available primarily to those counties participating in regional support networks.

[1989 c 205 § 6.]

NOTES:

Evaluation of transition to regional systems -- 1989 c 205: See note following RCW 71.24.015.

RCW 71.24.400
Streamlining delivery system -- Finding.

The legislature finds that the current complex set of federal, state, and local rules and regulations, audited and administered at multiple levels, which affect the community mental health service delivery system, focus primarily on the process of providing mental health services and do not sufficiently address consumer and system outcomes. The legislature finds that the department and the community mental health service delivery system must make ongoing efforts to achieve the purposes set forth in RCW 71.24.015 related to reduced administrative layering, duplication, and reduced administrative costs.

[1999 c 10 § 10; 1995 c 96 § 1; 1994 c 259 § 1.]

NOTES:

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

Effective date -- 1995 c 96: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect immediately [April 18, 1995]." [1995 c 96 § 5.]

RCW 71.24.405
Streamlining delivery system -- Project outcome.

The department shall establish a single comprehensive and collaborative project within regional support networks and with local mental health service providers aimed at creating innovative and streamlined community mental health service delivery systems, in order to carry out the purposes set forth in RCW 71.24.400 and to capture the diversity of the community mental health service delivery system.

The project must accomplish the following:

(1) Identification, review, and cataloging of all rules, regulations, duplicative administrative and monitoring functions, and other requirements that currently lead to inefficiencies in the community mental health service delivery system and, if possible, eliminate the requirements;

(2) The systematic and incremental development of a single system of accountability for all federal, state, and local funds provided to the community mental health service delivery system. Systematic efforts should be made to include federal and local funds into the single system of accountability;

(3) The elimination of process regulations and related contract and reporting requirements. In place of the regulations and requirements, a set of outcomes for mental health adult and children clients according to chapter 71.24 RCW must be used to measure the performance of mental health service providers and regional support networks. Such outcomes shall focus on stabilizing out-of-home and hospital care, increasing stable community living, increasing age-appropriate activities, achieving family and consumer satisfaction with services, and system efficiencies;

(4) Evaluation of the feasibility of contractual agreements between the department of social and health services and regional support networks and mental health service providers that link financial incentives to the success or failure of mental health service providers and regional support networks to meet outcomes established for mental health service clients;

(5) The involvement of mental health consumers and their representatives in the pilot projects. Mental health consumers and their representatives will be involved in the development of outcome standards for mental health clients and other related aspects of the pilot projects; and

(6) An independent evaluation component to measure the success of the projects.

[1999 c 10 § 11; 1995 c 96 § 2; 1994 c 259 § 2.]

NOTES:

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

Effective date -- 1995 c 96: See note following RCW 71.24.400.

RCW 71.24.415
Streamlining delivery system -- Department duties to achieve outcomes.

To carry out the purposes specified in RCW 71.24.400, the department is encouraged to utilize its authority to eliminate any unnecessary rules, regulations, standards, or contracts, to immediately eliminate duplication of audits or any other unnecessarily duplicated functions, and to seek any waivers of federal or state rules or regulations necessary to achieve the purpose of streamlining the community mental health service delivery system and infusing it with incentives that reward efficiency, positive outcomes for clients, and quality services.

[1999 c 10 § 12; 1995 c 96 § 3; 1994 c 259 § 4.]

NOTES:

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

Effective date -- 1995 c 96: See note following RCW 71.24.400.

RCW 71.24.450
Mentally ill offenders -- Findings and intent.

(1) Many acute and chronically mentally ill offenders are delayed in their release from Washington correctional facilities due to their inability to access reasonable treatment and living accommodations prior to the maximum expiration of their sentences. Often the offender reaches the end of his or her sentence and is released without any follow-up care, funds, or housing. These delays are costly to the state, often lead to psychiatric relapse, and result in unnecessary risk to the public.

These offenders rarely possess the skills or emotional stability to maintain employment or even complete applications to receive entitlement funding. Nation-wide only five percent of diagnosed schizophrenics are able to maintain part-time or full-time employment. Housing and appropriate treatment are difficult to obtain.

This lack of resources, funding, treatment, and housing creates additional stress for the mentally ill offender, impairing self-control and judgment. When the mental illness is instrumental in the offender's patterns of crime, such stresses may lead to a worsening of his or her illness, reoffending, and a threat to public safety.

(2) It is the intent of the legislature to create a pilot program to provide for postrelease mental health care and housing for a select group of mentally ill offenders entering community living, in order to reduce incarceration costs, increase public safety, and enhance the offender's quality of life.

[1997 c 342 § 1.]

NOTES:

Severability -- 1997 c 342: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1997 c 342 § 6.]

RCW 71.24.455
Mentally ill offenders -- Contracts for specialized access and services.

(1) The secretary shall select and contract with a regional support network or private provider to provide specialized access and services to mentally ill offenders upon release from total confinement within the department of corrections who have been identified by the department of corrections and selected by the regional support network or private provider as high-priority clients for services and who meet service program entrance criteria. The program shall enroll no more than twenty-five offenders at any one time, or a number of offenders that can be accommodated within the appropriated funding level, and shall seek to fill any vacancies that occur.

(2) Criteria shall include a determination by department of corrections staff that:

(a) The offender suffers from a major mental illness and needs continued mental health treatment;

(b) The offender's previous crime or crimes have been determined by either the court or department of corrections staff to have been substantially influenced by the offender's mental illness;

(c) It is believed the offender will be less likely to commit further criminal acts if provided ongoing mental health care;

(d) The offender is unable or unlikely to obtain housing and/or treatment from other sources for any reason; and

(e) The offender has at least one year remaining before his or her sentence expires but is within six months of release to community housing and is currently housed within a work release facility or any department of corrections' division of prisons facility.

(3) The regional support network or private provider shall provide specialized access and services to the selected offenders. The services shall be aimed at lowering the risk of recidivism. An oversight committee composed of a representative of the department, a representative of the selected regional support network or private provider, and a representative of the department of corrections shall develop policies to guide the pilot program, provide dispute resolution including making determinations as to when entrance criteria or required services may be waived in individual cases, advise the department of corrections and the regional support network or private provider on the selection of eligible offenders, and set minimum requirements for service contracts. The selected regional support network or private provider shall implement the policies and service contracts. The following services shall be provided:

(a) Intensive case management to include a full range of intensive community support and treatment in client-to-staff ratios of not more than ten offenders per case manager including: (i) A minimum of weekly group and weekly individual counseling; (ii) home visits by the program manager at least two times per month; and (iii) counseling focusing on relapse prevention and past, current, or future behavior of the offender.

(b) The case manager shall attempt to locate and procure housing appropriate to the living and clinical needs of the offender and as needed to maintain the psychiatric stability of the offender. The entire range of emergency, transitional, and permanent housing and involuntary hospitalization must be considered as available housing options. A housing subsidy may be provided to offenders to defray housing costs up to a maximum of six thousand six hundred dollars per offender per year and be administered by the case manager. Additional funding sources may be used to offset these costs when available.

(c) The case manager shall collaborate with the assigned prison, work release, or community corrections staff during release planning, prior to discharge, and in ongoing supervision of the offender while under the authority of the department of corrections.

(d) Medications including the full range of psychotropic medications including atypical antipsychotic medications may be required as a condition of the program. Medication prescription, medication monitoring, and counseling to support offender understanding, acceptance, and compliance with prescribed medication regimens must be included.

(e) A systematic effort to engage offenders to continuously involve themselves in current and long-term treatment and appropriate habilitative activities shall be made.

(f) Classes appropriate to the clinical and living needs of the offender and appropriate to his or her level of understanding.

(g) The case manager shall assist the offender in the application and qualification for entitlement funding, including medicaid, state assistance, and other available government and private assistance at any point that the offender is qualified and resources are available.

(h) The offender shall be provided access to daily activities such as drop-in centers, prevocational and vocational training and jobs, and volunteer activities.

(4) Once an offender has been selected into the pilot program, the offender shall remain in the program until the end of his or her sentence or unless the offender is released from the pilot program earlier by the department of corrections.

(5) Specialized training in the management and supervision of high-crime risk mentally ill offenders shall be provided to all participating mental health providers by the department and the department of corrections prior to their participation in the program and as requested thereafter.

(6) The pilot program provided for in this section must be providing services by July 1, 1998.

[1997 c 342 § 2.]

NOTES:

Severability -- 1997 c 342: See note following RCW 71.24.450.

RCW 71.24.460
Mentally ill offenders -- Report to legislature -- Contingent termination of program.

The department, in collaboration with the department of corrections and the oversight committee created in RCW 71.24.455, shall track outcomes and submit to the legislature annual reports regarding services and outcomes. The reports shall include the following: (1) A statistical analysis regarding the reoffense and reinstitutionalization rate by the enrollees in the program set forth in RCW 71.24.455; (2) a quantitative description of the services provided in the program set forth in RCW 71.24.455; and (3) recommendations for any needed modifications in the services and funding levels to increase the effectiveness of the program set forth in RCW 71.24.455. By December 1, 2003, the department shall certify the reoffense rate for enrollees in the program authorized by RCW 71.24.455 to the office of financial management and the appropriate legislative committees. If the reoffense rate exceeds fifteen percent, the authorization for the department to conduct the program under RCW 71.24.455 is terminated on January 1, 2004.

[1999 c 10 § 13; 1997 c 342 § 4.]

NOTES:

Purpose -- Intent -- 1999 c 10: See note following RCW 71.24.025.

Severability -- 1997 c 342: See note following RCW 71.24.450.

RCW 71.24.470
Dangerous mentally ill offenders -- Contract for case management -- Use of appropriated funds.

(1) The secretary shall contract, to the extent that funds are appropriated for this purpose, for case management services and such other services as the secretary deems necessary to assist offenders identified under RCW 72.09.370. The contracts may be with regional support networks or any other qualified and appropriate entities.

(2) The case manager has the authority to assist these offenders in obtaining the services, as set forth in the plan created under RCW 72.09.370(2), for up to five years. The services may include coordination of mental health services, assistance with unfunded medical expenses, obtaining chemical dependency treatment, housing, employment services, educational or vocational training, independent living skills, parenting education, anger management services, and such other services as the case manager deems necessary.

(3) The legislature intends that funds appropriated for the purposes of RCW 72.09.370, 71.05.145, and 71.05.212, and this section and distributed to the regional support networks are to supplement and not to supplant general funding. Funds appropriated to implement RCW 72.09.370, 71.05.145, and 71.05.212, and this section are not to be considered available resources as defined in RCW 71.24.025 and are not subject to the statutory distribution formula established pursuant to RCW 71.24.035.

[1999 c 214 § 9.]

NOTES:

Intent -- Effective date -- 1999 c 214: See notes following RCW 72.09.370.

RCW 71.24.900
Effective date -- 1967 ex.s. c 111.

This act shall take effect on July 1, 1967.

[1967 ex.s. c 111 § 26.]

RCW 71.24.901
Severability -- 1982 c 204.

If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

[1982 c 204 § 28.]

RCW 71.24.902
Construction.

Nothing in this chapter shall be construed as prohibiting the secretary from consolidating within the department children's mental health services with other departmental services related to children. [1986 c 274 § 7.]

Appendix Three

Chapter 388-865 WAC

COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

SECTION ONE -- COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

SECTION TWO -- REGIONAL SUPPORT NETWORKS

SECTION THREE -- MENTAL HEALTH PREPAID HEALTH PLANS

SECTION SIX -- DEPARTMENT OF CORRECTIONS ACCESS TO CONFIDENTIAL MENTAL HEALTH INFORMATION

WAC 388-865-0100 Purpose. Chapter 388-865 of the Washington Administrative Code implements chapters 71.05, 71.24, and 71.34 RCW, and the mental health Title XIX Section 1915 (b) Medicaid waiver provisions.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0100, filed 5/31/01, effective
7/1/01.]

WAC 388-865-0105 What the mental health division does and how it is organized.
(1) The department of social and health services is designated by the legislature as the state mental health authority, and has designated the mental health division to administer the state mental health program.
(2) To request an organizational chart, contact the mental health division at 1-888-713-6010 or (360) 902-8070, or write to the Mental Health Division Director, PO Box 45320, Olympia, WA 98504.
(3) Local services are administered by regional support networks (RSN), which are a county, or combination of counties, whose telephone number is located in the local telephone directory and can also be obtained by calling the mental health division at the above telephone number. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0105, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0110 Access to records of registration. The mental health division, regional support networks, mental health prepaid health plans, and service providers must ensure that information about the fact that a consumer has or is receiving mental health services is not shared or released except as specified under RCW 71.05.390 and other laws and regulations about confidentiality as noted below in WAC 388-865-0115. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0110, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0115 Access to clinical records. There are numerous federal and state rules and regulations on the subjects of confidentiality and access to consumer clinical records. Many of the rules are located in chapter 70.02 RCW, RCW 71.05.390, 71.05.400, 71.05.410, 71.05.420, 71.05.430, 71.05.440, 71.05.445, 71.05.610 through 71.05.680, 71.34.160, 71.34.162, 71.34.170,71.34.200 , 71.34.210, 71.34.220, 71.34.225, 13.50.100(4)(b), and 42 C.F.R. 431 and 438, and 42 C.F.R. Part 2 of the Code of Federal Regulations and are not repeated in these rules. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0115, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0120 Waiver of a minimum standard of this chapter. (1) A regional support network, mental health prepaid health plan, service provider or applicant subject to the rules in this chapter may request a waiver of any sections or subsections of these rules by submitting a request in writing to the director of the mental health division. The request must include:
(a) The name and address of the entity that is making the request;
(b) The specific section or subsection of these rules for which a waiver is being requested;

(c) The reason why the waiver is necessary, or the method the entity will use to meet the desired outcome of the section or subsection in a more effective and efficient manner;

(d) A description of the plan and timetable to achieve compliance with the minimum standard or to implement, test, and report results of an improved way to meet the intent of the section or subsection. In no case will the mental health division write a waiver of minimum standards for more than the time period of the entity's current license and/or certificate.

(2) For agencies contracting with a regional support network or mental health prepaid health plan, a statement by the regional support network or mental health prepaid health plan recommending mental health division approval of the request, including:

(a) Recommendations, if any, from the quality review team or ombuds staff; and

(b) A description of how consumers will be notified of changes made as a result of the exception.

(3) The mental health division makes a determination on the waiver request within thirty days from date of receipt. The review will consider the impact on accountability, accessibility, efficiency, consumer satisfaction, and quality of care and any violations of the request with state or federal law.

(4) When granting the request, the mental health division issues a notice to the person making the request, and the involved regional support network if the regional support network is not the applicant, that includes:

(a) The section or subsection waived;

(b) The conditions of acceptance;

(c) The timeframe for which the waiver is approved;

(d) Notification that the agreement may be reviewed by the mental health division and renewed, if requested.

(5) When denying the request, the mental health division includes the reason for the decision in the notice sent to the person making the request.

(6) The mental health division does not waive any requirement that is part of statute. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0120, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0150 Definitions. "Adult" means a person on or after their eighteenth birthday. For persons eligible for the Medicaid program, adult means a person on or after his/her twenty-first birthday.

"Child" means a person who has not reached his/her eighteenth birthday. For persons eligible for the Medicaid program, child means a person who has not reached his/her twenty-first birthday.

"Clinical services" means those direct age and culturally appropriate consumer services which either:

(1) Assess a consumer's condition, abilities or problems;

(2) Provide therapeutic interventions which are designed to ameliorate psychiatric symptoms and improve a consumer's functioning. "Consumer" means a person who has applied for, is eligible for or who has received mental health services. For a child, under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians. "Consultation" means the clinical review and development of recommendations regarding the job responsibilities, activities, or decisions of, clinical staff, contracted employees, volunteers, or students by persons with appropriate knowledge and experience to make recommendations. "Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs. "Ethnic minority" or "racial/ethnic groups" means, for the purposes of this
chapter, any of the following general population groups:

(1) African American;

(2) An American Indian or Alaskan native, which includes:

(a) A person who is a member of considered to be a member in a federally recognized tribe;

(b) A person determined eligible to be found Indian by the secretary of interior, and

(c) An Eskimo, Aleut, or other Alaskan native.

(d) A Canadian Indian, meaning a person of a treaty tribe, Metis community, or nonstatus Indian community from Canada.

(e) An unenrolled Indian meaning a person considered Indian by a federally or nonfederally recognized Indian tribe or off reservation Indian/Alaskan native community organization.

(3) Asian/Pacific Islander; or

(4) Hispanic.

"Medical necessity" or "medically necessary" - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Mental health division" means the mental health division of the Washington state department of social and health services (DSHS). DSHS has designated the mental health division as the state mental health authority to administer the state and Medicaid funded mental health program authorized by chapter 71.05, 71.24, and 71.34 RCW.

"Mental health professional" means:

(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;

(2) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(4) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

(5) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265.

"Mental health specialist" means:

(1) A "child mental health specialist" is defined as a mental health professional with the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A "geriatric mental health specialist" is defined as a mental health professional who has the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and

(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An "ethnic minority mental health specialist" is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

(4) A "disability mental health specialist" is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(a) If the consumer is deaf, the specialist must be a mental health professional with:

(i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities must be a mental health professional who:

(i) Has at least one year's experience working with people with developmental disabilities; or

(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

"Older person" means an adult who is sixty years of age or older.

"Service recipient" means for the purposes of a mental health prepaid health plan, a consumer eligible for the Title XIX Medicaid program.

"Substantial hardship" means that a consumer will not be billed for emergency involuntary treatment if he or she meets the eligibility standards of the medically indigent program that is administered by the DSHS medical assistance administration.

"Supervision" means monitoring of the administrative, clinical, or clerical work performance of staff, students, volunteers, or contracted employees by persons with the authority to give direction and require change.

"Underserved" means consumers who are:

(1) Minorities;

(2) Children;

(3) Older adults;

(4) Disabled; or

(5) Low-income persons.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0150, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0200 Regional support networks. The mental health division contracts with certified regional support networks to administer all mental health services activities or programs within their jurisdiction using available resources. The regional support network must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To gain and maintain certification, the regional support network must comply with all applicable federal, state and local laws and regulations, and all of the minimum standards of this section. The community mental health program administered by the regional support network includes the following programs:

(1) Administration of the involuntary treatment program, including investigation, detention, transportation, court related and other services required by chapter 71.05 and 71.34 RCW;

(2) Resource management program as defined in RCW 71.24.025(15) and this section;

(3) Community support services as defined in RCW 71.24.025(7);

(4) Residential and housing services as defined in RCW 71.24.025(14);

(5) Ombuds services;

(6) Quality review teams;

(7) Inpatient services as defined in chapter 71.05 and 71.34 RCW; and

(8) Services operated or staffed by consumers, former consumers, family members of consumers, or other advocates. If the service is clinical, the service must comply with the requirements for licensed services. Consumer or advocate run services may include, but are not limited to:

(a) Consumer and/or advocate operated businesses;

(b) Consumer and/or advocate operated and managed clubhouses;

(c) Advocacy and referral services;

(d) Consumer and/or advocate operated household assistance programs;

(e) Self-help and peer support groups;

(f) Ombuds service; and

(g) Other services.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0200, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0201 Allocation of funds to RNS/PHPs. This section describes how Medicaid and community mental health funds are allocated to the RSN/PHPs.

(1) Funding allocations are projected at the beginning of each fiscal year, using forecasted Medicaid enrollees for that fiscal year.

(2) Payments are made on the number of actual Medicaid enrollees each month, which may result in actual payments being higher or lower than projected payments, depending on whether actual Medicaid enrollees are more or less than forecasted enrollees.

(3) The mental health division (MHD) uses two different methodologies to allocate funds:

(a) Historical method;

(b) Eligibles method.

(4) For the period July 1, 2001 to June 30, 2005, the funds will be allocated using the methodologies as follows:

(a) For July, 1, 2001 to June 30, 2002, seventy-five percent of funds of will be allocated using the historical method and twenty-five percent of funds will be allocated using the prevalence method;

(b) For June 1, 2002 to June 30, 2003, fifty percent of funds will be allocated using the historical method and fifty percent of funds will be allocated using the prevalence method;

(c) For June 1, 2003 to June 30, 2004, twenty-five percent of funds will be allocated using the historical method and seventy-five percent of funds will be allocated using the prevalence method;

(d) For June 1, 2004 forward, one hundred percent of funds will be allocated using the prevalence method. These percentages will remain in effect unless the department is directed otherwise by the state Legislature.

(5)(a) Historical method means that federal Medicaid funds projected to be paid to the RSN/PHPs are calculated using actuarially determined per member per month (PMPM) rates specific to each regional support network multiplied by the number of persons enrolled in the Medicaid program in each regional support network for each month during the fiscal year.

(b) The actuarially determined rates were determined at the beginning of the managed care program (1992 for outpatient services and 1997 for inpatient services) and have been increased periodically by the Legislature.

(i) Rates differ by RSN and by category of enrollee (disabled and nondisabled adults and disabled and nondisabled children).

(ii) These rates are tracked by MHD.

(iii) The number of Medicaid enrollees is tracked by the medical assistance administration.

(c) The product of rates and enrollees is the projected amount of Medicaid funding each RSN/PHP will receive during the year.

(i) This amount is divided into two portions - federal funds and state match funds.

(ii) The two portions of Medicaid funds are determined by a percentage known as the Federal Medicaid Assistance Percentage (FMAP). This percentage is set by the federal Health Care Financing Authority and changes each year.

(d) In the inpatient program, each RSN/PHP is allocated the amount of federal and state funds projected in the calculations explained above.

(e) State funds in the outpatient program (also called "consolidated") to be paid to the RSN/PHPs are set by the Legislature. These funds are allocated to the RSN/PHPs according to the RSN/PHP's calculated percentage of the total funds. The RSN/PHP's percentage is based primarily on historical fee-for-service data.

(i) The RSN/PHP percentages are tracked by MHD and are carried forward each year.

(ii) The percentage of consolidated funds paid to each RSN/PHP is adjusted each year by the Legislature through budget proviso direction, generally requiring that new funds in the program be allocated according to Medicaid enrollees in each RSN. Therefore, the amount of consolidated funds in the outpatient program at the beginning of the fiscal year (also called "base funds") are allocated according to the percentage tracked by MHD (put in place by the Legislature in the previous year).

(iii) New consolidated funds are allocated as directed by the Legislature, generally according to the number of Medicaid enrollees residing in each RSN.

(f) The base allocation and new consolidated allocations are combined into one percentage that serves as the RSN/PHP's percentage allocation for the next year's base funds.

(g) The sum of federal Medicaid funds, state match funds in the inpatient program, and consolidated funds equals the amount of funding provided to each RSN/PHP.

(6) Eligibles method.

(a) Medicaid and non-Medicaid funds are allocated based on a formula that reflects prevalence of mental disorders in each county. The formula takes into consideration each RSN's:

(i) Concentrations of priority populations;

(ii) Commitments to state hospitals under chapter 71.05 and 71.34 RCW;

(iii) Population concentrations in urban areas;

(iv) Population concentrations at border crossings at state boundaries; and

(v) Other demographic and workload factors such as number of MI/GA-U clients, commitments to community hospitals under chapter 71.05 and 71.34 RCW, and number of homeless persons.

(b) The RSN/PHP historical method rates for 2001 have been used to calculate a weighted average statewide rate (WASR) for each category of Medicaid eligible (disabled and nondisabled adults and disabled and nondisabled children).

(c) The WASR for each category is determined by:

(i) Adding the RSN/PHP's inpatient and outpatient rates to create one combined rate;

(ii) Multiplying each RSN/PHP's rate by the number of Medicaid enrollees residing in that RSN/PHP;

(iii) Adding the results; and

(iv) Dividing the sum by the state-wide number of Medicaid eligibles.

(d) WASR rates are tracked by MHD.

(e) The number of Medicaid enrollees is tracked by the medical assistance administration.

(f) To project the amount of Medicaid funding each RSN/PHP will receive during the year, MHD multiplies the RSN/PHP's WASR for each category by the projected number of Medicaid enrollees in each category.

(i) This amount is divided into two portions - federal funds and state match funds.

(ii) Each RSN/PHP's projected allocation includes both portions of Medicaid funding (federal and state match funds).

(iii) Payments to the RSN/PHP are made based on the actual number of Medicaid enrollees.

(g) The level of non-Medicaid funds appropriated to the community mental health services program is determined by the state Legislature.

(i) Eighty percent of the non-Medicaid funds appropriated are allocated to the RSN/PHPs according to the number persons enrolled in the state funded general assistance - unemployable, medically indigent and state only "v" programs (persons in the state only "v" program are counted at thirteen percent of the total enrolled).

(A) The number of persons enrolled in these programs is tracked by the medical assistance administration.

(B) The projected number of persons in these programs residing in each RSN, divided by the total persons projected to be in these programs, is multiplied by eighty percent of the total funds appropriated to determine the amount of funding provided to each RSN/PHP.

(ii) Twenty percent of the non-Medicaid funds appropriated are allocated according to a summary z score factor that is calculated using four sub-factors:

(A) The number of urban counties in each RSN;

(B) The number of state and country border counties in each RSN;

(C) The number of homeless persons in each RSN; and

(D) The number of ITA commitments from each RSN.

These sub-factors are weighted differently, with the urban factor weighted at 0.3, the border county factor weighted at 0.05, the homeless factor weighted at 1.0 and the ITA commitments factor weighted at 0.2. For each of these factors, information is tracked by MHD and the most recent complete year of data is used to calculate z score factors for each sub-factor. These factors are combined into a summary z score factor for each RSN that is multiplied by the total funding available (twenty percent of non-Medicaid funds appropriated).

(7) The mental health division does not pay providers on a fee-for-service basis for services that are the responsibility of the mental health RSN or PHP, even if the RSN or PHP has not paid for the service for any reason.

(8) To the extent authorized by the state legislature, regional support networks and mental health prepaid health plans may use local funds spent on health services to increase the collection of federal Medicaid funds. Local funds used for this purpose may not be used as match for any other federal funds or programs.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0201, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0203 Allocation formula for state hospital beds. The mental health division (MHD) allocates nonforensic adult beds at the state hospital utilized by the regional support network (RSN) based on the number of beds funded by the Legislature at that hospital.

(1) The allocation formula is (M x 40%)+(U x 35%)+(P x 25%) x F.

(a) M is the average number of Medicaid eligible persons in the RSN during the period of January to December prior to the start of the biennium, divided by the average number of Medicaid eligible persons at each state hospital catchment area (westside for western state hospital and eastside for eastern state hospital) during the same period;

(b) U is the number of each regional support network's average daily census at the state hospital during the period of January to December prior to the start of each biennium divided by the average daily census at the hospital based on the utilization of beds by the regional support network included in the hospital catchment area during the same period;

(c) P is the percent of the general population that resides within the RSN based on the most recent population estimate on December 1 of the year prior to the start of the biennium divided by the general population in the hospital catchment area at the same time;

(d) F is the total number of funded nonforensic beds at each state hospital (westside for western state hospital and eastside for eastern state hospital);

(e) The MHD will project and distribute tentative allocations upon issuance of the Governor's budget, and upon enactment of the Legislative budget. The operative allocation will be made and distributed at the start of each fiscal year.

(2) This formula will be phased in as follows:

(a) For July 1, 2001 to June 30, 2002, twenty five percent of the bed allocation will be based on the new formula, and seventy five percent based on the 1999-2001 allocation;

(b) For July 1, 2002 to June 30, 2003, fifty percent of the allocation will be based on the new formula and fifty percent based on the 1999-2001 allocation;

(c) For July 1, 2003 to June 30, 2004, seventy-five percent of the allocation will be based on the new formula and twenty-five percent based on the 1999-2001 allocation;

(d) For July 1, 2004 to June 30, 2005 one hundred percent of the allocation will be based on the new formula;

(e) The formula will be recalculated on or about April 4, 2005 and each biennium thereafter based on data that is current at that time.

(3) If the in-residence census exceeds the funded capacity on any day or days within the fiscal year, the MHD will assess liquidated damages calculated on the following formula:

(a) Only RSNs who are in excess of their individual allocated census on the day or each day of over census will be assessed liquidated damages;

(b) The amount of liquidated damages charged for each day will be the number of beds over the funded capacity of the hospital multiplied by the state hospital daily bed charge consistent with RCW 43.20B.325;

(c) The amount of liquidated damages charged to each RSN will be a percentage based on the number of beds over their allocation divided by the total number of beds over the funded capacity on the day or each day of over census;

(d) The liquidated damages will be recovered by the MHD by a deduction from the monthly payment made by the MHD two months after the end of the month in which the in residence census exceeded the state bed allocation of that RSN.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0203, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0205 Initial certification of a regional support network. A regional support network is a county authority or group of county authorities that have a joint operating agreement. In order to gain certification as a regional support network, a county or group of counties must submit to the department:

(1) A statement of intent to become a regional support network;

(2) Documentation that the total population in the county or group of counties is not less than forty thousand;

(3) A joint operating agreement if the proposed regional support network is more than one county or includes a tribal authority. The agreement must include the following:

(a) Identification of a single authority with final responsibility for all available resources and performance of the contract with the department consistent with chapter 71.05, 71.24, and 71.34 RCW;

(b) Assignment of all responsibilities required by RCW 71.24.300; and

(c) Participation of tribal authorities in the agreement at the request of the tribal authorities.

(d) A preliminary operating plan completed according to departmental guidelines.

(4) Within thirty days of the submission the department will provide a written response either:

(a) Certifying the regional support network; or

(b) Denying certification because the requirements are not met.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0205, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0210 Renewal of regional support network certification. At least biennially the mental health division reviews the compliance of each regional support network with the statutes, applicable rules and regulations, applicable standards, and state minimum standards as defined in this chapter:

(1) If the regional support network is in compliance with the statutes, applicable rules and regulations, applicable standards, and state minimum standards, the mental health division provides the regional support network with a written certificate of compliance.

(2) If the regional support network is not in compliance with the statutes, applicable rules and regulations, the mental health division will provide the regional support network written notice of the deficiencies. In order to maintain certification, the regional support network must develop a plan of corrective action approved by the mental health division.

(3) If the regional support network fails to develop an approved plan of corrective action or does not complete implementation of the plan within the timeframes specified, the mental health division may initiate procedures to suspend, revoke, limit, or restrict certification consistent with the provisions of RCW 71.24.035 (7) through (11) and of 43.20A.205. The mental health division sends a written decision to revoke, suspend, or modify the former certification,

with the reasons for the decision and informing the regional support network of its right to an administrative hearing.

(4) The mental health division may suspend or revoke the certification of a regional support network immediately if the mental health division determines that deficiencies imminently jeopardize the health and safety of consumers. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0210, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0215 Consumer eligibility and payment for services. (1) Within available resources as defined in RCW 71.24.025(2), the regional support network must serve consumers in the following order of priority as defined in RCW 71.24.035 (5)(b):

(a) Acutely mentally ill persons;

(b) Chronically mentally ill adults and severely emotionally disturbed children;

(c) Seriously disturbed persons.

(2) Consumers eligible for the Title XIX Medicaid program are entitled to receive covered medically necessary services from a mental health prepaid health plan without charge to the consumer;

(3) The consumer or the parent(s) of a child who has not reached their eighteenth birthday, the legal guardian, or the estate of the consumer is responsible for payment for services provided. The consumer may apply to the following entities for payment assistance:

(a) DSHS for medical assistance;

(b) The community support provider for payment responsibility based on a sliding fee scale; or

(c) The regional support network for authorization of payment for involuntary evaluation and treatment services for consumers who would experience a substantial hardship as defined in WAC 388-865-0150.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0215, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0220 Standards for administration. The regional support network must demonstrate that it meets the requirements of chapter 71.05, 71.24, and 71.34 RCW, and ensures the effectiveness and cost effectiveness of community mental health services in an age and culturally competent manner. The regional support network must:

(1) Establish a governing board that includes, where applicable, representation from tribal authorities, consistent with RCW 71.24.300;

(2) For multi-county regional support networks, function as described in the regional support network joint operating agreement;

(3) Ensure the protection of consumer and family rights as described in this chapter, and chapter 71.05 and 71.34 RCW; and other applicable statutes for consumers involved in multiservice systems;

(4) Collaborate with and make reasonable efforts to obtain and use resources in the community to maximize services to consumers;

(5) Educate the community regarding mental illness to diminish stigma;

(6) Maintain agreement(s) with sufficient numbers of certified involuntary inpatient evaluation and treatment facilities to ensure that persons eligible for regional support network services have access to inpatient care;

(7) Develop publicized forums in which to seek and include input about service needs and priorities from community stakeholders, including:

(a) Consumers;

(b) Family members and consumer advocates;

(c) Culturally diverse communities including consumers who have limited English proficiency;

(d) Service providers;

(e) Social service agencies;

(f) Organizations representing persons with a disability;

(g) Tribal authorities; and

(h) Underserved groups.

(8) Maintain job descriptions for regional support staff with qualifications for each position with the education, experience, or skills relevant to job requirements; and

(9) Provide orientation and ongoing training to regional support network staff in the skills pertinent to the position and the treatment population, including age and culturally competent consultation with consumers, families, and community members.

(10) Identify trends and address service gaps;

(11) The regional support network must provide an updated two-year plan biennially to the mental health division for approval consistent with the provisions of RCW 71.24.300(1). The biennial plan must be submitted to the

regional support network governing board for approval and to the advisory board for review and comment. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0220, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0221 Public awareness of mental health services. The regional support network or its designee must provide public information on the availability of mental health services. The regional support network must:

(1) Maintain listings of services in telephone directories and other public places such as libraries, community services offices, juvenile justice facilities, of the service area. The regional support network or its designee must prominently display listings for crisis services in telephone directories;

(2) Publish and disseminate brochures and other materials or methods for describing services and hours of operation that are appropriate for all individuals, including those who may be visually impaired, limited-English proficient, or unable to read;

(3) Post and make information available to consumers regarding the ombuds service consistent with WAC 388-865-0250, and local advocacy organizations that may assist consumers in understanding their rights. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0221, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0222 Advisory board. The regional support network must promote active engagement with persons with mental disorders, their families and services providers by soliciting and using their input to improve its services. The regional support network must appoint an advisory board that:

(1) Is broadly representative of the demographic character of the region and the ethnicity and broader cultural aspects of consumers served;

(2) Is composed of at least fifty-one percent:

(a) Current consumers or past consumers of public mental health services, including those who are youths, older adults, or who have a disability; and

(b) Family, foster family members, or care givers of consumers, including parents of emotionally disturbed children.

(3) Independently reviews and provides comments to the regional support network governing board on plans, budgets, and policies developed by the regional support network to implement the requirements of this section, chapter 71.05, 71.24, 71.34 RCW and applicable federal law and regulations.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0222, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0225 Resource management. The regional support network must establish mechanisms which maximize access to and use of age and culturally competent mental health services, and ensure eligible consumers receive appropriate levels of care. The regional support network must:

(1) Authorize admission, transfers and discharges for eligible consumers into and out of the following services:

(a) Community support services;

(b) Residential services; and

(c) Inpatient evaluation and treatment services.

(2) Ensure that services are provided according to the consumer's individualized service plan;

(3) Not require preauthorization of emergency services and transportation for emergency services that are required by an eligible consumer;

(4) Identify in the agreement with the mental health division any of these duties it has delegated to a subcontractor. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0225, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0229 Inpatient services. The regional support network must develop and implement age and culturally competent services that are consistent with chapter 71.24, 71.05, and 71.34 RCW. The regional support network must:

(1) For voluntary inpatient services: Develop and implement formal agreements with inpatient services funded by the regional support network regarding:

(a) Referrals;

(b) Admissions; and

(c) Discharges.

(2) For involuntary evaluation and treatment services:

(a) Maintain agreements with sufficient numbers of certified involuntary evaluation and treatment facilities to ensure that consumers eligible for regional support network services have access to involuntary inpatient care. The agreements must address regional support network responsibility for discharge planning;

(b) Determine which service providers on whose behalf the regional support network will apply on behalf of for certification by the mental health division;

(c) Ensure that all service providers or its subcontractors that provide evaluation and treatment services are currently certified by the mental health division and licensed by the department of health;

(d) Ensure periodic reviews of the evaluation and treatment service facilities consistent with regional support network procedures and notify the appropriate authorities if it believes that a facility is not in compliance with applicable statutes, rules and regulations.

(3) Authorize admissions, transfers and discharges into and out of inpatient evaluation and treatment services for eligible consumers including:

(a) State psychiatric hospitals:

(i) Western state hospital;

(ii) Eastern state hospital;

(iii) Child study and treatment center.

(b) Community hospitals;

(c) Residential inpatient evaluation and treatment facilities licensed by the department of health as adult residential rehabilitation centers; and

(d) Children's long-term inpatient program.

(4) Receive prior approval from the mental health division in the form of a single bed certification for services to be provided to consumers on a ninety- or one hundred eighty-day community inpatient involuntary commitment order consistent with the exception criteria in WAC 388-865-0502; and

(5) Identify in the agreement with the mental health division any of these duties is has delegated to a subcontractor. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0229, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0230 Community support services. The regional support network must develop and coordinate age and culturally competent community support services that are consistent with chapter 71.24, 71.05, and 71.34 RCW:

(1) Provide the following services directly, or contract with sufficient numbers and variety of licensed and/or certified service providers to ensure that persons eligible for regional support network services have access to at least the following services:

(a) Emergency crisis intervention services;

(b) Case management services;

(c) Psychiatric treatment including medication supervision;

(d) Counseling and psychotherapy services;

(e) Day treatment services as defined in RCW 71.24.300(5) and 71.24.035(7); and

(f) Consumer employment services as defined in RCW 71.24.035 (5)(e).

(2) Conduct prescreening determinations for providing community support services for persons with mental illness who are being considered for placement in nursing homes (RCW 71.24.025(7) and 71.24.025(9)); and

(3) Complete screening for persons with mental illness who are being considered for admission to residential services funded by the regional support network (RCW 71.24.025 and 71.24.025(9)). [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0230, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0235 Residential and housing services. The regional support network must ensure:

(1) Active promotion of consumer access to, and choice in, safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.

(2) Provision of services to families of eligible children and to eligible consumers who are homeless or at imminent risk of becoming homeless as defined in Public Law 100-77, through outreach, engagement and coordination or linkage of services with shelter and housing.

(3) The availability of community support services, with an emphasis supporting consumers in their own home or where they live in the community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in RCW 71.24.025 (7) and (14); and chapter 71.24.025(14) RCW.

(4) That eligible consumers in residential facilities receive mental health services consistent with their individual service plan, and are advised of their rights, including long-term care rights (chapter 70.129 RCW).

(5) If supervised residential services are needed they are provided only in licensed facilities:

(a) An adult family home that is licensed under chapter 388-76 WAC.

(b) A boarding home facility that is licensed under chapter 388-78A WAC.

(c) An adult residential rehabilitative center facility that is licensed under chapter 246-325 WAC.

(6) The active search of comprehensive resources to meet the housing needs of consumers.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0235, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0240 Consumer employment services. The regional support network must coordinate with rehabilitation and employment services to assure that consumers wanting to work are provided with employment services consistent with WAC 388-865-0464. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0240, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0245 Administration of the Involuntary Treatment Act. The regional support network must establish policies and procedures for administration of the involuntary treatment program, including investigation, detention, transportation, court related and other services required by chapter 71.05 and 71.34 RCW. This includes:

(1) Designating mental health professionals to perform the duties of involuntary investigation and detention in accordance with the requirements of chapter 71.05 and 71.34 RCW.

(2) Documenting consumer compliance with the conditions of less restrictive alternative court orders by:

(a) Ensuring periodic evaluation of each committed consumer for release from or continuation of an involuntary treatment order. Evaluations must be recorded in the clinical record, and must occur at least monthly for ninety and one hundred eighty-day commitments.

(b) Notifying the county designated mental health professional if noncompliance with the less restrictive order impairs the individual sufficiently to warrant detention or evaluation for detention and petitioning for revocation of the less restrictive alternative court order.

(3) Ensuring that when a peace officer or county designated mental health professional escorts a consumer to a facility, the county designated mental health professional must take reasonable precautions to safeguard the consumer's property including:

(a) Safeguarding the consumer's property in the immediate vicinity of the point of apprehension;

(b) Safeguarding belongings not in the immediate vicinity if there may be possible danger to those belongings;

(c) Taking reasonable precautions to lock and otherwise secure the consumer's home or other property as soon as possible after the consumer's initial detention.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0245, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0250 Ombuds services. The regional support network must provide unencumbered access to and maintain the independence of the ombuds service as set forth in this section and in the agreement between mental health division and the regional support network. The mental health division and the regional support network must include representatives of consumer and family advocate organizations when revising the terms of the agreement regarding the requirements of this section. Ombuds members must be current consumers of the mental health system, past consumers or family members. The regional support network must maintain an ombuds service that:

(1) Is responsive to the age and demographic character of the region and assists and advocates for consumers with resolving complaints and grievances at the lowest possible level;

(2) Is independent of service providers;

(3) Receives and investigates consumer, family member, and other interested party complaints and grievances;

(4) Is accessible to consumers, including a toll-free, independent phone line for access;

(5) Is able to access service sites and records relating to the consumer with appropriate releases so that it can reach out to consumers, and resolve complaints and/or grievances;

(6) Receives training and adheres to confidentiality consistent with this chapter and chapter 71.05, 71.24, and 70.02 RCW;

(7) Continues to be available to investigate, advocate and assist the consumer through the grievance and administrative hearing processes;

(8) Involves other persons, at the consumer's request;

(9) Assists consumers in the pursuit of formal resolution of complaints;

(10) If necessary, continues to assist the consumer through the fair hearing processes;

(11) Coordinates and collaborates with allied systems' advocacy and ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared clients;

(12) Provides information on grievance experience to the regional support network and mental health division quality management process; and

(13) Provides reports and formalized recommendations at least biennially to the mental health division and regional support network advisory and governing boards, quality review team, local consumer and family advocacy groups, and provider network.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0250, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0255 Consumer grievance process. The regional support network must develop a process for reviewing consumer complaints and grievances. A complaint is defined as a verbal statement of dissatisfaction with some aspect of mental health services. A grievance is a written request that a complaint be heard and adjudicated, usually undertaken after attempted resolution of a complaint fails. The process must be submitted to the mental health division for written approval and incorporation into the agreement between the regional support network and the mental health division. The process must:

(1) Be age, culturally and linguistically competent;

(2) Ensure acknowledgment of receipt of the grievance the following working day. This acknowledgment may be by telephone, with written acknowledgment mailed within five working days;

(3) Ensure that grievances are investigated and resolved within thirty days. This timeframe can be extended by mutual written agreement, not to exceed ninety days;

(4) Be published and made available to all current or potential users of publicly funded mental health services and advocates in language that is clear and understandable to the individual;

(5) Encourage resolution of complaints at the lowest level possible;

(6) Include a formal process for dispute resolution;

(7) Include referral of the consumer to the ombuds service for assistance at all levels of the grievance and fair hearing processes;

(8) Allow the participation of other people, at the grievant's choice;

(9) Ensure that the consumer is mailed a written response within thirty days from the date a written grievance is received by the regional support network;

(10) Ensure that grievances are resolved even if the consumer is no longer receiving services;

(11) Continue to provide mental health services to the grievant during the grievance and fair hearing process;

(12) Ensure that full records of all grievances are kept for five years after the completion of the grievance process in confidential files separate from the grievant's clinical record. These records must not be disclosed without the consumer's written permission, except as necessary to resolve the grievance or to DSHS if a fair hearing is requested;

(13) Provide for follow-up by the regional support network to assure that there is no retaliation against consumers who have filed a grievance;

(14) Make information about grievances available to the regional support network;

(15) Inform consumers of their right to file an administrative hearing with DSHS without first accessing the contractor's grievance process. Consumers must utilize the regional support network grievance process prior to requesting disenrollment;

(16) Inform consumers of their right to use the DSHS prehearing and administrative hearing processes as described in chapter 388-02 WAC. Consumers have this right when:

(a) The consumer believes there has been a violation of DSHS rule;

(b) The regional support network did not provide a written response within thirty days from the date a written request was received;

(c) The regional support network, mental health prepaid health plan, the department of social and health services, or a provider denies services. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0255, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0260 Mental health professionals and specialists. The regional support network must assure sufficient numbers of mental health professionals and specialists are available in the service area to meet the needs of eligible consumers. The regional support network must:

(1) Document efforts to acquire the services of the required mental health professionals and specialists;

(2) Ensure development of a training program using in-service training or outside resources to assist service providers to acquire necessary skills and experience to serve the needs of the consumer population;

(3) If more than five hundred persons in the total population in the regional support network geographic area report in the U.S. census that they belong to racial/ethnic groups as defined in WAC 388-865-0150, the regional support network must contract or otherwise establish a working relationship with the required specialists to:

(a) Provide all or part of the treatment services for these populations; or

(b) Supervise or provide consultation to staff members providing treatment services to these populations. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0260, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0265 Mental health professional -- Exception. The regional support network may request an exception of the requirements of a mental health professional for a person with less than a masters degree level of training. The mental health division may grant an exception of the minimum requirements on a time-limited basis and only with a demonstrated need for an exception under the following conditions:

(1) The regional support network has made a written request for an exception including:

(a) Demonstration of the need for an exception;

(b) The name of the person for whom an exception is being requested;

(c) The functions which the person will be performing;

(d) A statement from the regional support network that the person is qualified to perform the required functions based on verification of required education and training, including:

(i) Bachelor of Arts or Sciences degree from an accredited college or university;

(ii) Course work or training in making diagnoses, assessments, and developing treatment plans; and

(iii) Documentation of at least five years of direct treatment of persons with mental illness under the supervision of a mental health professional.

(2) The regional support network assures that periodic supervisory evaluations of the individual's job performance are conducted;

(3) The regional support network submits a plan of action to assure the individual will become qualified no later than two years from the date of exception. The regional support network may apply for renewal of the exception. The exception may not be transferred to another regional support network or to use for an individual other than the one named in the exception;

(4) If compliance with this rule causes a disproportionate economic impact on a small business as defined in the Regulatory Fairness Act, chapter 19.85 RCW, and the business does not contract with a regional support network, the small business may request the exception directly from the mental health division.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0265, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0270 Financial management. The regional support network must be able to demonstrate that it ensures the effectiveness and cost effectiveness of community mental health services. The regional support network must:

(1) Spend funds received by the mental health division in accordance with its contract and to meet the requirements of chapter 71.05, 71.24, 71.34 RCW, and the State Appropriations Act;

(2) Use accounting procedures that are consistent with applicable state and federal requirements and generally accepted accounting principles (GAAP), with the following additional requirements:

(a) Include as assets all property, equipment, vehicles, buildings, capital reserve funds, operating reserve funds, risk reserve funds, or self-insurance funds.

(b) Interest accrued on funds stated in this section must be accounted for and kept for use by the regional support network.

(c) Property, equipment, vehicles, and buildings must be properly inventoried with a physical inventory conducted at least every two years.

(d) Proceeds from the disposal of any assets must be retained by the regional support network for purposes of subsection (1) of this section.

(3) Comply with the 1974 county maintenance of effort requirement for administration of the Involuntary Treatment Act (chapter 71.05 RCW) and 1990 county maintenance of effort requirement for community programs for adults consistent with RCW 71.24.160, and in the case of children, no state funds shall replace local funds from any source used to finance administrative costs for involuntary commitment procedures conducted prior to January 1, 1985 (chapter 71.34 RCW);

(4) Maintain accounting procedures to ensure that accrued interest and excess reserve balances are returned to the regional support network for use in the public mental health system.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0270, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0275 Management information system. The regional support network must be able to demonstrate that it collects and manages information that shows the effectiveness and cost effectiveness of mental health services. The regional support network must:

(1) Operate an information system and ensure that information about consumers who receive publicly funded mental health services is reported to the state mental health information system according to mental health division guidelines.

(2) Ensure that the information reported is:

(a) Sufficient to produce accurate regional support network reports; and

(b) Adequate to locate case managers in the event that a consumer requires treatment by a service provider that would not normally have access to treatment information about the consumer.

(3) Ensure that information about consumers is shared or released between service providers only in compliance with state statutes (see chapter 70.02, 71.05, and 71.34 RCW) and this chapter. Information about consumers and their individualized crisis plans must be available:

(a) Twenty-four hours a day, seven days a week to county-designated mental health professionals and inpatient evaluation and treatment facilities, as consistent with confidentiality statutes; and

(b) To the state and regional support network staff as required for management information and program review.

(4) Maintain on file a statement signed by regional support network, county or service provider staff having access to the mental health information systems acknowledging that they understand the rules on confidentiality and will follow the rules.

(5) Take appropriate action if a subcontractor or regional support network employee willfully releases confidential information, as required by chapter 71.05 RCW. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0275, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0280 Quality management process. The regional support network must implement a process for continuous quality improvement in the delivery of culturally competent mental health services. The regional support network must submit a quality management plan as part of the written biennial plan to the mental health division for approval. All changes to the quality management plan must be submitted to the mental health division for approval prior to implementation. The plan must include:

(1) Roles, structures, functions and interrelationships of all the elements of the quality management process, including but not limited to the regional support network governing board, clinical and management staff, advisory board, ombuds service, and quality review teams.

(2) Procedures to ensure that quality management activities are effectively and efficiently carried out with clear management and clinical accountability, including methods to:

(a) Collect, analyze and display information regarding:

(i) The capacity to manage resources and services, including financial and cost information and compliance with statutes, regulations and agreements;

(ii) System performance indicators;

(iii) Quality and intensity of services;

(iv) Incorporation of feedback from consumers, allied service systems, community providers, ombuds and quality review team;

(v) Clinical care and service utilization including consumer outcome measures; and

(vi) Recommendations and strategies for system and clinical care improvements, including information from exit interviews of consumers and practitioners.

(b) Monitor management information system data integrity;

(c) Monitor complaints, grievances and adverse incidents for adults and children;

(d) Monitor contracts with contractors and to notify the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements;

(e) Immediately investigate and report allegations of fraud and abuse of the contractor or subcontractor to the mental health division;

(f) Monitor delegated administrative activities;

(g) Identify necessary improvements;

(h) Interpret and communicate practice guidelines to practitioners;

(i) Implement change;

(j) Evaluate and report results;

(k) Demonstrate use of all corrective actions to improve the system;

(l) Consider system improvements based on recommendations from all on-site monitoring, evaluation and accreditation/certification reviews;

(m) Review update, and make the plan available to community stakeholders.

(3) Targeted improvement activities, including:

(a) Performance measures that are objective, measurable, and based on current knowledge/best practice including at least those defined by the mental health division in the agreement with the regional support network;

(b) An analysis of consumer care covering a representative sample of at least ten percent of consumers or five hundred consumers, whichever is smaller;

(c) Efficient use of human resources; and

(d) Efficient business practices. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0280, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0282 Quality review teams. The regional support network must establish and maintain unencumbered access to and maintain the independence of a quality review team as set forth in this section and in the agreement between mental health division and the regional support network. The quality review team must include current consumers of the mental health system, past consumers or family members. The regional support network must assure that quality review teams:

(1) Fairly and independently review the performance of the regional support network and service providers to evaluate systemic customer service issues as measured by objective indicators of consumer outcomes in rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, including:

(a) Quality of care;

(b) The degree to which services are consumer-focused/ directed and are age and culturally competent;

(c) The availability of alternatives to hospitalization, cross-system coordination and range of treatment options; and

(d) The adequacy of the regional support network's cross system linkages including, but not limited to schools, state and local hospitals, jails and shelters.

(2) Have the authority to enter and monitor any agency providing services for area regional support network consumers, including state and community hospitals, freestanding evaluation and treatment facilities, and community support service providers;

(3) Meet with interested consumers and family members, allied service providers, including state or community psychiatric hospitals, regional support network contracted service providers, and persons that represent the age and ethnic diversity of the regional support network to:

(a) Determine if services are accessible and address the needs of consumers based on sampled individual recipient's perception of services using a standard interview protocol developed by the mental health division. The protocol will query the sampled individuals regarding ease of accessing services, the degree to which services address medically necessary needs (acceptability), and the benefit of the service received; and

(b) Work with interested consumers, service providers, the regional support network, and DSHS to resolve identified problems.

(4) Provide reports and formalized recommendations at least biennially to the mental health division, the mental health advisory committee and the regional support network advisory and governing boards and ensure that input from the quality review team is integrated into the overall regional support network quality management process, ombuds services, local consumer and family advocacy groups, and provider network; and

(5) Receive training and adhere to confidentiality standards.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0282, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0284 Standards for contractors and subcontractors. The regional support network must not subcontract for clinical services to be provided using state funds unless the subcontractor is licensed and/or certified by the mental health division for those services or is personally licensed by the department of health as defined in chapter 48.43, 18.57, 18.71, 18.83, or 18.79 RCW. The regional support network must:

(1) Require and maintain documentation that contractors and subcontractors are licensed, certified, or registered in accordance with state or federal laws;

(2) Follow applicable requirements of the regional support network agreement with the mental health division;

(3) Demonstrate that it monitors contracts with contractors and notifies the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements; and

(4) Terminate its contract with a provider if the mental health division notifies the regional support network of a provider's failure to attain or maintain licensure or certification, if applicable.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0284, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0286 Coordination with a mental health prepaid health plan. If the regional support network is not also a mental health prepaid health plan, the regional support network must ensure continuity of services between itself and the mental health prepaid health plan by maintaining a working agreement about coordination for at least the following services:

(1) Community support services;

(2) Inpatient evaluation and treatment services;

(3) Residential services;

(4) Transportation services;

(5) Consumer employment services;

(6) Administration of involuntary treatment investigation and detention services; and

(7) Immediate crisis response after presidential declaration of a disaster.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0286, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0288 Regional support networks as a service provider. A regional support network may operate as a community support service provider under the following circumstances:

(1) Meeting the criteria specified in RCW 71.24.037 and 71.24.045;

(2) Maintaining a current license as a community support service provider from the mental health division. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0288, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0300 Mental health prepaid health plans. A mental health prepaid health plan is an entity that contracts with the mental health division to administer mental health services for people who are eligible for the Title XIX Medicaid program. The mental health prepaid health plan must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To be eligible for a contract as a mental health prepaid health plan, the entity must:

(1) Provide documentation of a population base of forty-one thousand six hundred Medicaid eligible persons (covered lives) within the service area or receive approval from the mental health division based on submittal of an actuarially sound risk management profile;

(2) Maintain certification as a regional support network or licensure by the Washington state office of the insurance commissioner as a health care service contractor under chapter 48.44 RCW. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0300, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0305 Regional support network contracting as a mental health prepaid health plan. A regional support network contracting with the mental health division as a mental health prepaid health plan must comply with all requirements for a regional support network and the additional requirements for a prepaid health plan. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0305, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0310 Mental health prepaid health plans -- Minimum standards. To be eligible for a contract, a mental health prepaid health plan must comply with all applicable federal, state, and local statutes and regulations and meet all of the minimum standards of WAC 388-865-300 through 388-865-355. The mental health prepaid health plan must:

(1) Provide medically necessary mental health services that are age and culturally competent for all Medicaid recipients in the service area within a capitated rate;

(2) Provide outreach to consumers, including homeless persons and families as defined in Public Law 100-77, and home-bound individuals;

(3) Demonstrate working partnerships with tribal authorities for the delivery of services that blend with tribal values, beliefs and culture;

(4) Develop and maintain written subcontracts that clearly recognize that legal responsibility for administration of the service delivery system remains with the mental health prepaid health plan, as identified in the agreement with the mental health division;

(5) Retain responsibility to ensure that applicable standards of state and federal statute and regulations and this chapter are met even when it delegates duties to subcontractors;

(6) Ensure the protection of consumer and family rights as described in chapter 71.05 and 71.34 RCW;

(7) Ensure compliance with the following standards:

(a) WAC 388-865-0220, Standards for administration;

(b) WAC 388-865-0225, Resource management program;

(c) WAC 388-865-0229, Inpatient services and treatment services;

(d) WAC 388-865-0230, Community support services;

(e) WAC 388-865-0250, Ombuds services;

(f) WAC 388-865-0255, Consumer grievance process;

(g) WAC 388-865-0260, Mental health professionals or specialists;

(h) WAC 388-865-0265, Mental health professional -- Exception;

(i) WAC 388-865-0270, Financial management;

(j) WAC 388-865-0275, Management information system;

(k) WAC 388-865-0280, Quality management process;

(l) WAC 388-865-0282, Quality review teams; and

(m) WAC 388-865-0284, Standards for contractors and subcontractors.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0310, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0315 Governing body. The mental health prepaid health plan must establish a governing body responsible for oversight of the mental health prepaid health plan. The governing body must:

(1) Be free from conflict of interest and all appearance of conflict of interest between personal, professional and fiduciary interests of a governing body member and the best interests of the prepaid health plan and the consumers it serves.

(2) Have rules about:

(a) When a conflict of interest becomes evident;

(b) Not voting or joining a discussion when a conflict of interest is present; and

(c) When the body scan assign the matter to others, such as staff or advisory bodies. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0315, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0320 Utilization management. Utilization management is the way the mental health prepaid health plan authorizes or denies mental health services, monitors services, and follows the level of care guidelines. To demonstrate the impact on enrollee access to care of adequate quality, a mental health prepaid health plan must provide utilization management of the community mental health rehabilitation services (42 C.F.R. 440) that is independent of service providers. This process must:

(1) Provide effective and efficient management of resources;

(2) Assure capacity sufficient to deliver appropriate quality and intensity of services to enrolled consumers without a wait list consistent with the agreement with the mental health division;

(3) Plan, coordinate, and authorize community support services;

(4) Ensure that services are provided according to the individual service plan;

(5) Ensure assessment and monitoring processes are in place by which service delivery capacity responds to changing needs of the community and enrolled consumers;

(6) Develop, implement, and enforce written level of care guidelines for admission, placements, transfers and discharges into and out of services. The guidelines must address:

(a) A clear process for the mental health prepaid health plan's role in the decision-making process about admission and continuing stay at various levels is available in language that is clearly understood by all parties involved in an individual consumer's care, including laypersons;

(b) Criteria for admission into various levels of care, including community support, inpatient and residential services that are clear and concrete;

(c) Methods to ensure that services are individualized to meet the needs for all Medicaid consumers served, including consumers of different ages, cultures, languages, civil commitment status, physical abilities, and unique service needs; and

(d) To the extent authorization of care at any level of care or at continuing stay determinations is delegated, the mental health prepaid health plan retains a sufficiently strong and regular oversight role to assure those decisions are being made appropriately.

(7) Collect data that measures the effectiveness of the criteria in ensuring that all eligible people get services that are appropriate to his/her needs;

(8) Report to the mental health division any knowledge it gains that the mental health prepaid health plan or service provider is not in compliance with all state and federal laws and regulations.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0320, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0325 Risk management. The mental health prepaid health plan must:

(1) Assume the financial risk of providing community mental health outpatient rehabilitation services, community hospital services and operation of a capitated mental health managed care system for the Medicaid eligible persons in the service area;

(2) Maintain a risk reserve of annual premium payments as defined by chapter 48.44 RCW or the actuarial analysis submitted with the formal request for waiver for mental health approved by the Health Care Financing Administration. All other mental health reserves and undesignated fund balances shall be limited to no more than ten percent of annual revenues supporting the prepaid health plan's mental health program;

(3) Demonstrate solvency and manage all fiscal matters within the managed care system, including:

(a) Current pro-forma;

(b) Financial reports;

(c) Balance sheets;

(d) Revenue and expenditure; and

(e) An analysis of reserve account(s) and fund balance(s) information including a detailed composition of capital, operating, and risk reserves and or fund balances.

(4) Maintain policies for each reserve account and have a process for collecting and disbursing reserves to pay for costs incurred by the mental health prepaid health plan;

(5) Demonstrate capacity to process claims for members of the contracted provider network and any emergency service providers accessed by consumers while out of the mental health prepaid health plan service area within sixty days using methods consistent with generally accepted accounting practices;

(6) Comply with the requirements of section 1128 (b) of the Social Security Act, which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to consumers;

(7) In accordance with the Medicaid section 1915b waiver, the mental health prepaid health plan is required to pay for psychiatric inpatient services in community hospitals either through a direct contract with community hospitals or through an agreement with the department. In the event that the mental health prepaid health plan chooses to use the department as its fiscal agent, the plan agrees to abide by all policies, rules, payment requirements, and levels promulgated by the medical assistance administration. If the plan chooses to direct contract, the plan is responsible for executing contracts for sufficient hospital capacity pursuant to a plan approved by the mental health division. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0325, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0330 Marketing/education of mental health services. The mental health prepaid health plan must demonstrate that it provides information to eligible persons so that they are aware of available mental health services and how to access them. The mental health prepaid health plan must:

(1) Develop and submit marketing/education plan(s) and procedures to the mental health division within the timeframes in the agreement with the mental health division for approval prior to issuance. The plan shall, at a minimum, include information on the following:

(a) Consumer rights and responsibilities;

(b) The service recipient's right to disenroll;

(c) Cross-system linkages;

(d) Access to mental health services for diverse populations, including other languages than English;

(e) Use of media;

(f) Stigma reduction;

(g) Subcontractor participation/involvement;

(h) Plan for evaluation of marketing strategy;

(i) Procedures and materials, and any revisions thereof; and

(j) Maintain listings of mental health services with toll-free numbers in the telephone and other public directories of the service area.

(2) Describe services and hours of operations through brochures and other materials and other methods of advertising;

(3) Assure that the materials and methods are effective in reaching people who may be visually impaired, have limited comprehension of written or spoken English, or who are unable to read. At a minimum, all written materials generally available to service recipients shall be translated to the most commonly used languages in the service area;

(4) Post and otherwise make information available to consumers about ombuds services and local advocacy organizations that may assist consumers in understanding their rights;

(5) Ensure distribution of written educational material(s) to consumers, allied systems and local community resources including:

(a) Annual brochure(s) containing educational material on major mental illnesses and the range of options for treatment, supports available in the system, including medication and formal psychotherapies, as well as alternative approaches that may be appropriate to age, culture and preference of the service recipient;

(b) Information regarding the scope of available benefits (e.g., inpatient, outpatient, residential, employment, community support);

(c) Service locations, crisis response services; and

(d) Service recipients' responsibilities with respect to out-of-area emergency services; unauthorized care; noncovered services; complaint process, grievance procedures; and other information necessary to assist in gaining access.

(6) Ensure marketing plans, procedures and materials are accurate and do not mislead, confuse or defraud the service recipient.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0330, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0335 Consumer enrollment. (1) DSHS enrolls a Medicaid recipient in a mental health prepaid health plan when the person resides in the contracted service area;

(2) An enrolled Medicaid consumer who requests or receives medically necessary nonemergency community mental health rehabilitation services requests and receives such service from the assigned mental health prepaid health plan through authorized providers only;

(3) An enrolled Medicaid consumer does not need to request disenrollment from the mental health division when the recipient moves from one mental health prepaid health plan to another.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0335, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0340 Consumer disenrollment. (1) The mental health division must disenroll a Medicaid consumer from his/her mental health prepaid health plan only when the consumer:

(a) Loses eligibility for Title XIX Medicaid services; or

(b) Is deceased.

(2) On a case-by-case basis, the mental health division will disenroll a consumer from his/her mental health prepaid health plan when the consumer has "good cause" for disenrollment. For the purposes of this chapter, "good cause" is defined as the inability of the mental health prepaid health plan to provide medically necessary care that is reasonably available and accessible. A consumer will not be disenrolled in a mental health prepaid health plan solely due to an adverse change in the consumer's health. In determining whether the mental health prepaid health plan provides medically necessary care that is reasonably available and accessible the mental health division may consider, but is not limited to considering:

(a) The medically necessary services needed by the consumer;

(b) Whether services are or should be available to other consumers in the mental health prepaid health plan;

(c) Attempts the consumer has made to access services in his/her assigned mental health prepaid health plan;

(d) Efforts by the assigned mental health prepaid health plan to provide the medically necessary services needed by the consumer.

(3) A consumer wishing to disenroll from his/her assigned mental health prepaid health plan must utilize the local mental health prepaid health plan grievance process prior to requesting disenrollment from the mental health

division;

(4) A consumer requesting disenrollment must make a request in writing to the mental health division fair hearing coordinator. The request must include:

(a) The consumer's name, address, phone number (or number where the consumer can receive a message), and the name of the consumer's current mental health prepaid health plan;

(b) A statement outlining the reasons why the consumer believes his/her current mental health prepaid health plan does not provide medically necessary care that is reasonably available and accessible.

(5) The mental health division will make a decision within forty-five days of the request for disenrollment or within time frames prescribed by the federal Health Care Financing Administration, whichever is shorter. The mental health division will screen the request to determine if there is sufficient information upon which to base a decision;

(6) The mental health division will notify the consumer within fifteen days of receipt of the request whether or not the request contains sufficient information. If there is not sufficient information to allow the mental health division to make a decision, additional information will be requested from the consumer. The consumer will have fifteen days to provide requested information. Failure to provide additional requested information will result in denial of the disenrollment request;

(7) The mental health division will send written notice of the decision to the consumer:

(a) If a decision to disenroll is made, the mental health division will notify the consumer ten days in advance of the effective date of the proposed disenrollment, including arrangements for continued mental health services;

(b) If the consumer's request to disenroll is denied, the notice will include the consumer's right to request a fair hearing, how to request a fair hearing, and how the consumer may access ombuds services in his/her area. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0340, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0345 Choice of primary care provider. The mental health prepaid health plan must ensure that each consumer who is receiving nonemergency community mental health rehabilitation services has a primary care provider who is responsible to carry out the individualized service plan. The mental health prepaid health plan must allow consumers, parents of consumers under the age of thirteen, and guardians of consumers of all ages to select a primary care provider from the available primary care provider staff within the mental health prepaid health plan.

(1) For an enrolled client with an assigned case manager, the case manager is the primary care provider;

(2) If the consumer does not make a choice, the mental health prepaid health plan or its designee must assign a primary care provider no later than fifteen working days after the consumer requests services;

(3) The mental health prepaid health plan or its designee must allow a consumer to change primary care providers in the first ninety days of enrollment with the mental health prepaid health plan and once during a twelve-month period for any reason;

(4) Any additional change of primary care provider during the twelve-month period may be made with documented justification at the consumer's request by: (a) Notifying the mental health prepaid health plan (or its designee) of his/her request for a change, and the name of the new primary care provider; and (b) Identifying the reason for the desired change.

(5) A consumer whose request to change primary care providers is denied may submit a grievance with the plan, or request an administrative hearing.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0345, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0350 Mental health screening for children. The mental health prepaid health plan is responsible for conducting mental health screening and treatment for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program. This includes:

(1) Providing resource management services for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program as specified in contract with the mental health division;

(2) Developing and maintaining an oversight committee for the coordination of the early and periodic screening, diagnosis and treatment program. The oversight committee must include representation from parents of Medicaid-eligible children.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0350, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0355 Consumer request for a second opinion. An enrolled consumer in a mental health prepaid health plan must have the right to a second opinion by another participating staff in the enrolled consumer's assigned mental health prepaid health plan:

(1) When the enrolled consumer needs more information about the medical necessity of the treatment recommended by the mental health prepaid health plan; or

(2) If the enrolled consumer believes the mental health prepaid health plan primary care provider is not authorizing medically necessary community mental health rehabilitation services.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0355, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0360 Monitoring of mental health prepaid health plans. The mental health division will conduct an annual on-site medical audit and an administrative audit at least every two years for purposes of assessing the quality of care and conformance with the minimum standards of this section and the Title XIX Medicaid 1915(b) mental health waiver requirements. The monitoring will include a review of:

(1) The mental health prepaid health plan's conformance to monitoring its service provider network in accordance with the quality management plan approved by the mental health division that includes processes established under the Medicaid waiver for mental health services;

(2) Any direct services provided by the mental health prepaid health plan;

(3) Other provisions within the code of federal regulations for managed care entities, which may include access, quality of care, marketing, record keeping, utilization management and disenrollment functions. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0360, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0363 Coordination with the regional support network. If the mental health prepaid health plan is not also a regional support network, the mental health prepaid health plan must ensure continuity of services between itself and the regional support network by maintaining a working agreement about coordination for at least the following services:

(1) Residential services;

(2) Transportation services;

(3) Consumer employment services;

(4) Administration of involuntary treatment investigation and detention services; and

(5) Immediate crisis response after presidential declaration of a disaster.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0363, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0365 Suspension, revocation, limitation or restriction of a contract. The mental health division may suspend, revoke, limit or restrict a mental health prepaid health plan contract or refuse to grant a contract for failure to conform to applicable state and federal rules and regulations or for violation of health or safety considerations.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0365, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0400 Community support service providers. The mental health division licenses and certifies community support service providers. To gain and maintain licensure or certification, a provider must meet applicable local, state and federal statutes and regulations as well as the requirements of WAC 388-865-400 through 388-865-450 as applicable to services offered. The license or certificate lists service components the provider is authorized to provide to publicly funded consumers and must be prominently posted in the provider reception area. In addition, the provider must meet minimum standards of the specific service components for which licensure is being sought:

(1) Emergency crisis intervention services;

(2) Case management services;

(3) Psychiatric treatment, including medication supervision;

(4) Counseling and psychotherapy services;

(5) Day treatment services; and/or

(6) Consumer employment services.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0400, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0405 Competency requirements for staff. The licensed service provider must ensure that staff are qualified for the position they hold and have the education, experience, or skills to perform the job requirements. The provider must maintain documentation that:

(1) All staff have a current Washington state department of health license or certificate or registration as may be required for their position;

(2) Washington state patrol background checks are conducted for employees in contact with consumers consistent with RCW 43.43.830;

(3) Mental health services are provided by a mental health professional, or under the clinical supervision of a mental health professional;

(4) Staff performing mental health services (not including crisis telephone) must have access to consultation with a psychiatrist or a physician with at least one year's experience in the direct treatment of persons who have a mental or emotional disorder;

(5) Mental health services to children, older adults, ethnic minorities or persons with disabilities must be provided by, under the supervision of, or with consultation from the appropriate mental health specialist(s) when the consumer:

(a) Is a child as defined in WAC 866-865-0150;

(b) Is or becomes an older person as defined in WAC 388-865-0150;

(c) Is a member of a racial/ethnic group as defined in WAC 866-865-0105 and as reported:

(i) In the consumer's demographic data; or

(ii) By the consumer or others who provide active support to the consumer; or

(iii) Through other means.

(d) Is disabled as defined in WAC 388-865-0150 and as reported:

(i) In the consumer's demographic data; or

(ii) By the consumer or others who provide active support to the consumer; or

(iii) Through other means.

(6) Staff receive regular supervision and an annual performance evaluation; and

(7) An individualized annual training plan must be implemented for each direct service staff person and supervisor in the skills he or she needs for his/her job description and the population served.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0405, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0410 Consumer rights. (1) The provider must document that consumers, prospective consumers, or legally responsible others are informed of consumer rights at admission to community support services in a manner that is understandable to the individual. Consumer rights must be written in alternative format for consumers who are blind or deaf, and must also be translated to the most commonly used languages in the service area consistent with WA 388-865-0260(3);

(2) The provider must post a written statement of consumer rights in public areas, with a copy available to consumers on request. Providers of telephone only services (e.g., crisis lines) must post the statement of consumer rights in a location visible to staff and volunteers during working hours;

(3) The provider must develop a statement of consumer rights that incorporates the following statement or a variation approved by the mental health division: "You have the right to:

(a) Be treated with respect, dignity and privacy;

(b) Develop a plan of care and services which meets your unique needs;

(c) The services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;

(d) Refuse any proposed treatment, consistent with the requirements in chapter 71.05 and 71.34 RCW;

(e) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;

(f) Be free of any sexual exploitation or harassment;

(g) Review your clinical record and be given an opportunity to make amendments or corrections;

(h) Receive an explanation of all medications prescribed, including expected effect and possible side effects;

(i) Confidentiality, as described in chapters 70.02, 71.05, and 71.34 RCW and regulations;

(j) All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC;

(k) Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;

(l) Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;

(m) If you are Medicaid eligible, receive all service which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from a provider within the regional support network about what services are medically necessary;

(n) Lodge a complaint with the ombuds, regional support network, or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The ombuds may, at your request, assist you in filing a grievance. The ombuds' phone number is:_____."[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0410, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0415 Access to services. The community support service provider must document and otherwise ensure that eligible consumers have access to age and culturally competent services when and where those services are needed. The provider must:

(1) Identify and reduce barriers to people getting the services where and when they need them;

(2) Comply with the Americans with Disabilities Act and the Washington State Antidiscrimination Act, chapter 49.60 RCW;

(3) Assure that services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the consumer;

(4) Provide alternative service delivery models to make services more available to underserved persons as defined in WAC 388-865-0150;

(5) Provide access to telecommunication devices or services and certified interpreters for deaf or hearing impaired consumers and limited English proficient consumers;

(6) Bring services to the consumer or locate services at sites where transportation is available to consumers; and

(7) Ensure compliance with all state and federal nondiscrimination laws, rules and plans. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0415, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0420 Intake evaluation. The community support service provider must complete an intake evaluation in collaboration with the consumer within fourteen days of admission to service. If seeking this information presents a barrier to service, the item may be left incomplete provided that the reasons are documented in the clinical record. The following must be documented in the consumer's intake evaluation:

(1) A consent for treatment or copy of detention or involuntary treatment order;

(2) Consumer strengths, needs and desired outcomes in their own words. At the consumer's request also include the input of people who provide active support to the consumer;

(3) The consumer's age, culture/cultural history, and disability;

(4) History of substance use and abuse or other co-occurring disorders;

(5) Medical and mental health services history and a list of medications used;

(6) For children:

(a) Developmental history; and

(b) Parent's goals and desired outcomes.

(7) Sufficient information to justify the diagnosis;

(8) Review of the intake evaluation by a mental health professional. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0420, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0425 Individual service plan. Community support service providers must provide consumers with an individual service plan that meets his or her unique needs. Individualized and tailored care is a planning process that may be used to develop a consumer-driven, strength-based, individual service plan. The individual service plan must:

(1) Be developed collaboratively with the consumer and other people identified by the consumer within thirty days of starting community support services. The service plan should be in language and terminology that is understandable to consumers and their family, and include goals that are measurable;

(2) Address age, cultural, or disability issues of the consumer;

(3) Include measurable goals for progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, involving other systems when appropriate;

(4) Demonstrate that the provider has worked with the consumer and others at the consumer's request to determine his/her needs in the following life domains:

(a) Housing;

(b) Food;
(c) Income;
(d) Health and dental care;
(e) Transportation;
(f) Work, school or other daily activities;
(g) Social life; and
(h) Referral services and assistance in obtaining supportive services appropriate to treatment, such as substance abuse treatment.

(5) Document review by the person developing the plan and the consumer. If the person developing the plan is not a mental health professional, the plan must also document review by a mental health professional. If the person developing the plan is not a mental health specialist required per WAC 388-865-405(5) there must also be documented consultation with the appropriate mental health specialist(s);

(6) Document review and update at least every one hundred eighty days or more often at the request of the consumer;

(7) In the case of children:

(a) Be integrated with the individual education plan from the education system whenever possible;

(b) If the child is under three, the plan must be integrated with the individualized family service plan (IFSP) if this exists, consistent with Title 20, Section 1436. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0425, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0430 Clinical record. The community support service provider must maintain a clinical record for each consumer and safeguard the record against loss, defacement, tampering, or use by unauthorized persons. The clinical record must contain:

(1) An intake evaluation;

(2) Evidence that the consumer rights statement was provided to the consumer;

(3) A copy of any advance directives, powers of attorney or letters of guardianship provided by the consumer;

(4) The crisis treatment plan when appropriate;

(5) The individualized service plan and all changes in the plan;

(6) Documentation that services are provided by or under the clinical supervision of a mental health professional;

(7) Documentation that services are provided by, or under the clinical supervision, or the clinical consultation of a mental health specialist. Consultation must occur within thirty days of admission and periodically thereafter as specified by the mental health specialist;

(8) Periodic documentation of the course of treatment and objective progress toward established goals for rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices;

(9) A notation of extraordinary events affecting the consumer;

(10) Documentation of mandatory reporting of abuse, neglect, or exploitation of consumers consistent with chapter 26.44 and 74.34 RCW;

(11) Documentation of informed consent to treatment and medications by the consumer or legally responsible other;

(12) Documentation of confidential information that has been released without the consent of the consumer including, but not limited to provisions in RCW 70.02.050, 71.05.390 and 71.05.630. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0430, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0435 Consumer access to their clinical record. The service provider must provide access to clinical records for consumers, their designated representative, and/or the person legally responsible for the consumer, consistent with chapter 71.05, 70.02, and 71.34 RCW and RCW 13.50.400 (4)(b) for children. The provider must:

(1) Make the record available within fifteen days;

(2) Review the clinical record to identify and remove any material confidential to another person, agency, provider or reports not originated by the community support service provider;

(3) Allow the consumer appropriate time and privacy to review the clinical record;

(4) Provide a clinical staff member to answer questions at the request of the consumer; and

(5) Charge for copying at a rate not higher than that defined in RCW 70.02.010(12). [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0435, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0436 Clinical record access procedures. The community support service provider must develop policies and procedures to protect information and to ensure that information about consumers is shared or released only in compliance with state and federal law (see chapter 70.02, 71.05, 71.34, 74.04 RCW and RCW 13.50.100 (4)(b)) and this chapter.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0436, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0440 Availability of consumer information. (1) Consumer individualized crisis plans as provided by the consumer must be available twenty-four hours a day, seven days a week to county-designated mental health professionals, crisis teams, and voluntary and involuntary inpatient evaluation and treatment facilities, as consistent with confidentiality statutes; and (2) Consumer information must be available to the state and regional support network staff as required for management information, quality management and program review. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0440, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0445 Establishment of procedures to bill for services. Consumers receiving services or the parent(s) of a person under the age of eighteen, the legal guardian, or the estate of the individual is responsible for payment for services received. The provider must establish policies and procedures to:

(1) Bill all third-party payors and private pay consumers. Persons eligible for the Medicaid program are not to be billed for medically necessary covered services.

(2) Develop a written schedule of fees that considers the consumer's available income, family size, allowable deductions and exceptional circumstances:

(a) Payment must not be required from consumers whose income is below TANF standards as defined in WAC 388-478-0020;

(b) The fee schedule must be posted in the agency and available to provider staff, consumers, the regional support network, and the mental health prepaid health plan. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0445, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0450 Quality management process. Community support service providers must ensure continued progress toward more effective and efficient age and culturally competent services and improved consumer satisfaction and outcomes, including objective measures of progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices by maintaining an internal quality management process. The process must:

(1) Review the services offered and provided to improve the treatment of consumers, including the quality of intake evaluations and the effectiveness of prescribed medications;

(2) Review the work of persons providing mental health services at least annually; and

(3) Continuously collect, maintain, and use information to correct deficiencies and improve services. Such data must include but is not limited to reports of serious and emergent incidents as well as grievances filed by consumers or their representatives.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0450, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0452 Emergency crisis intervention services -- Additional standards. The community support service provider that is licensed for emergency crisis intervention services must assure that required general minimum tandards for community support services are met, plus the additional minimum requirements:

(1) Availability of staff to respond to crises twenty-four hours a day, seven days a week, including:

(a) Bringing services to the person in crisis when clinically indicated;

(b) Requiring that staff remain with the consumer in crisis to stabilize and support him/her until the crisis is resolved or a referral to another service is accomplished;

(c) Resolving the crisis in the least restrictive manner possible;

(d) A process to include family members, significant others, and other relevant treatment providers as necessary to provide support to the person in crisis; and

(e) Written procedures for managing assaultive and/or self-injurious patient behavior.

(2) Crisis telephone screening;

(3) Mobile outreach and stabilization services with trained staff available to provide in-home or in-community stabilization services, including flexible supports to the person where he/she lives.

(4) Provide access to necessary services including:

(a) Medical services, which means at least emergency services, preliminary screening for organic disorders, prescription services, and medication administration;

(b) Interpretive services to enable staff to communicate with consumers who have limited ability to communicate in English, or have sensory disabilities;

(c) Mental health specialists for children, elderly, ethnic minorities or consumers who are deaf or developmentally disabled;

(d) Voluntary and involuntary inpatient evaluation and treatment services, including a written protocol to assure that consumers who require involuntary inpatient services are transported in a safe and timely manner;

(e) Investigation and detention to involuntary services under chapter 71.05 RCW for adults and chapter 71.34 RCW for children who are thirteen years of age or older, including written protocols for contacting the county designated mental health professional.

(5) Document all telephone and face-to-face crisis response contacts, including:

(a) Source of referral;

(b) Nature of crisis;

(c) Time elapsed from the initial contact to face-to-face response; and

(d) Outcomes, including basis for decision not to respond in person, follow-up contacts made, and referrals made.

(6) The provider must have a written protocol for referring consumers to a voluntary or involuntary inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the county designated mental health professional and transporting consumers. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0452, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0454 Provider of crisis telephone services only. This section applies only to organizations that receive public mental health funds for the purpose of providing crisis telephone services but are not licensed community support providers. In order to be licensed to provide crisis telephone services, the following requirements must be met:

(1) Staff available to respond to crisis calls twenty-four hours a day, seven days a week;

(2) The agency must assure communication and coordination with the consumer's case manager or primary care provider;

(3) The agency must assure that staff are aware of and protect consumer rights as described in WAC 388-865-0410;

(4) The following sections of WAC subsections apply:

(a) WAC 388-865-0405, Competency requirements for staff;

(b) WAC 388-865-0410, Consumer rights;

(c) WAC 388-865-0440, Availability of consumer information;

(d) WAC 388-865-0450, Quality management process;

(e) WAC 388-865-0452 (6)(a) thru (d), Emergency crisis intervention services--Additional standards;

(f) WAC 388-865-0468, The process for licensing service providers;

(g) WAC 388-865-0472, Licensing categories;

(h) WAC 388-865-0474, Fees for community support licensure;

(i) WAC 388-865-0476, Licensure based on deemed status;

(j) WAC 388-865-0478, Renewal of the provider license;

(k) WAC 388-865-0480, Procedures to suspend or revoke a license;

(l) WAC 388-865-0482, Procedures to contest a licensing decision.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0454, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0456 Case management services -- Additional standards. The community support service provider for case management services must assure that all general minimum standards for community support services and are met, plus the following additional minimum requirements:

(1) Assist consumers to achieve the goals stated in their individualized service plan;

(2) Support consumer employment, education or participation in other daily activities appropriate to their age and culture;

(3) Make referrals to other needed services and supports, including treatment for co-occurring disorders and health care;

(4) Assist consumers to resolve crises in least-restrictive settings;

(5) Provide information and education about the consumer's illness so the consumer and family and natural supports are engaged to help consumers manage the consumer's symptoms;

(6) Include, as necessary, flexible application of funds, such as rent subsidies, rent deposits, and in-home care to enable stable community living.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0456, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0458 Psychiatric treatment, including medication supervision -- Additional standards. The licensed community support service provider for psychiatric treatment, including medication supervision must meet all general minimum standards for community support in addition to the following minimum requirements:

(1) Document the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Document that consumers and, as appropriate, family members are informed about the medication and possible side effects in language that is understandable to the consumer, and referred to other health care facilities for treatment of nonpsychiatric conditions;

(2) Provider staff must inspect and inventory medication storage areas at least quarterly:

(a) Medications must be kept in locked, well-illuminated storage;

(b) Medications kept in a refrigerator containing other items must be kept in a separate container with proper security;

(c) No outdated medications must be retained, and medications must be disposed of in accordance with regulations of the state board of pharmacy;

(d) Medications for external use must be stored separately from oral and injectable medications;

(e) Poisonous external chemicals and caustic materials must be stored separately.

(3) Medical direction and responsibility is assigned to a physician who is licensed to practice under chapter 18.57 or 18.71 RCW, and is board-certified or -eligible in psychiatry;

(4) Medications are only prescribed and administered by persons consistent with their license and related requirements;

(5) Medications are reviewed at least every three months;

(6) Medication information is maintained in the clinical record and documents at least the following for each prescribed medication:

(a) Name and purpose of medication;

(b) Dosage and method of giving medication;

(c) Dates prescribed, reviewed, and renewed;

(d) The effects, interactions, and side effects the staff observes or the consumer reports spontaneously or as the result of questions from the staff;

(e) Any laboratory findings;

(f) Reasons for changing or stopping the medication; and

(g) Name and signature of prescribing person.

(7) Assessment and appropriate referrals to or consultation with a physician or other health care provider when physical health problems are suspected or identified;

(8) Address current medical concerns consistent with the individualized service plan;

(9) If the service provider is unable to employ or contract with a psychiatrist, a physician without board eligibility in psychiatry may be utilized, provided that:

(a) Psychiatrist consultation is provided to the physician at least monthly; and

(b) A psychiatrist is accessible in person, by telephone, or by radio communication to the physician for emergency consultation.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0458, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0460 Counseling and psychotherapy services -- Additional standards. The licensed community support service provider for counseling and psychotherapy services must assure that all general minimum standards for community support are met.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0460, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0462 Day treatment services -- Additional standards. The licensed community support service provider for day treatment services must assure that all general minimum standards for community support are met. Day treatment services are defined as work or other activities of daily living for consumers:

(1) Services for adults include:

(a) Training in basic living and social skills;

(b) Supported work and preparation for work;

(c) Vocational rehabilitation;
(d) Day activities; and, if appropriate;
(e) Counseling and psychotherapy services.
(2) Services for children include:
(a) Age-appropriate living and social skills;
(b) Educational and pre-vocational services;
(c) Day activities; and
(d) Counseling and psychotherapy services.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0462, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0464 Consumer employment services -- Additional standards. The community support service provider licensed for employment services must assure that all general minimum standards for community support and are met, plus the following additional minimum requirements:
(1) Assist consumers to achieve the goals stated in his/her individualized service plan and provide access to employment opportunities, including:
(a) A vocational assessment of work history, skills, training, education, and personal career goals;
(b) Information about how employment will affect income and benefits the consumer is receiving because of their disability;
(c) Active involvement with consumers served in creating and revising individualized job and career development plans;
(d) Assistance in locating employment opportunities that are consistent with the consumer's skills, goals, and interests;
(e) Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required; and
(f) Interaction with the consumer's employer to support stable employment and advise about reasonable accommodation in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Antidiscrimination law.
(2) Pay consumers according to the Fair Labor Standards Act; and ensure safety standards that comply with local and state regulations are in place if the provider employs consumers as part of the pre-vocational or vocational program;
(3) Coordinate efforts with other rehabilitation and employment services, such as:
(a) The division of vocational rehabilitation;
(b) The state employment services;
(c) The business community; and
(d) Job placement services within the community. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0464, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0466 Community support outpatient certification -- Additional standards. In order to provide services to consumers on a less restrictive alternative court order, providers must be licensed to provide the psychiatric and medical service component of community support services and be certified by the mental health division to provide involuntary treatment services consistent with WAC 388-865-0484. In addition, the provider must:
(1) Document in the consumer clinical record and otherwise ensure:
(a) Detained and committed consumers are advised of their rights under chapter 71.05 or 71.34 RCW and as follows:
(i) To receive adequate care and individualized treatment;
(ii) To make an informed decision regarding the use of antipsychotic medication and to refuse medication beginning twenty-four hours before any court proceeding that the consumer has the right to attend;
(iii) To maintain the right to be presumed competent and not lose any civil rights as a consequence of receiving evaluation and treatment for a mental disorder;
(iv) Of access to attorneys, courts, and other legal redress;
(v) To have the right to be told statements the consumer makes may be used in the involuntary proceedings; and
(vi) To have the right to have all information and records compiled, obtained, or maintained in the course of treatment kept confidential as defined in chapter 71.05 and 71.34 RCW.
(b) A copy of the less restrictive alternative court order and any subsequent modifications are included in the clinical record;

(c) Development and implementation of an individual service plan which addresses the conditions of the less restrictive alternative court order and a plan for transition to voluntary treatment;

(d) That the consumer receives psychiatric treatment including medication management for the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Such services must be provided:

(i) At least weekly during the fourteen-day period;

(ii) Monthly during the ninety-day and one-hundred eighty day periods of involuntary treatment unless the attending physician determines another schedule is more appropriate, and they record the new schedule and the reasons for it in the consumer's clinical record.

(2) Maintain written procedures for managing assaultive and/or self-destructive patient behavior, and provide training to staff in these interventions;

(3) Have a written protocol for referring consumers to an inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis;

(4) For consumers who require involuntary detention the protocol must also include procedures for:

(a) Contacting the county designated mental health professional regarding revocations and extension of less restrictive alternatives, and

(b) Transporting consumers. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0466, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0468 Emergency crisis intervention services certification -- Additional standards. In order to provide emergency services to a consumer who may need to be detained or who has been detained, the service provider must be licensed for emergency crisis intervention services and be certified by the mental health division to provide involuntary treatment services consistent with WAC 388-865-0484. In addition, the provider must:

(1) Be available seven-days-a-week, twenty-four-hours-per-day;

(2) Follow a written protocol for holding a consumer and contacting the county designated mental health professional;

(3) Provide or have access to necessary medical services;

(4) Have a written agreement with a certified inpatient evaluation and treatment facility for admission on a seven day a week, twenty four hour per day basis; and

(5) Follow a written protocol for transporting individuals to inpatient evaluation and treatment facilities. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0468, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0470 The process for initial licensing of service providers. An applicant for a community support license must comply with the following process:

(1) Complete and submit an application form, along with the required fee to the mental health division. A copy of the application form must be provided to the area regional support network. The regional support network may make written comments to the mental health division about the provider's application for licensure. The application must indicate the service components the applicant wants to offer, as listed in WAC 388-865-0400;

(2) A regional support network may submit an application to the mental health division to operate as a licensed community support service provider as defined in WAC 388-865-0288;

(3) The mental health division conducts an on-site review to examine agency policies and procedures, personnel records, clinical records, financial documents, and any other information that may be necessary to confirm compliance with minimum standards of this section;

(4) The consumer chart review is conducted during a second site review within twelve months of the issuance of the provisional license for the agency or service component if the site review is being conducted in response to a license application for a new agency or a new service component in a currently licensed agency;

(5) The mental health division may include representatives of the regional support network or mental health prepaid health plan in the licensing review process. If a provider is licensed based on deemed status as outlined in WAC 388-865-0476, input from the accrediting agency may be considered;

(6) The on-site review concludes with an exit conference that includes:

(a) Discussion of findings, if any;

(b) Statement of deficiencies requiring a plan of correction;

(c) A plan of correction signed by the applicant agency director and the mental health division review team representative with a completion date no greater than sixty days from the date of the exit conference, unless otherwise negotiated with the review team representative. Consumer health and safety concerns may require immediate corrective action.

(7) If the provider fails to correct the deficiencies noted within the agreed-upon timeframes, licensure will be denied. The mental health division notifies the applicant in writing of the reasons for denial and the right to a review of the decision in an administrative hearing;

(8) If licensure is denied, the applicant must wait at least six months following the date of notification of denial before reapplying.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0470, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0472 Licensing categories. The mental health division assigns the community support service applicant or licensee one of the following types of licenses:

(1) Provisional license. This category is given only to a new applicant. The mental health division may grant a provisional license for up to one year if the provider, has:

(a) An acceptable detailed plan for the development and operation of the services;

(b) The availability of administrative and clinical expertise required to develop and provide the planned services;

(c) The fiscal management and existence or projection of resources to reasonably ensure stability and solvency; and

(d) A corrective action plan approved by the mental health division, if applicable, for any deficiencies.

(2) Full License. Full licensure means that the applicant or licensee is in substantial compliance with the law, applicable rules and regulations, and state minimum standards.

(3) Probationary license. The mental health division may issue a probationary license if the service provider is substantially out of compliance with the requirements of state and federal law, applicable rules and regulations and state minimum standards. The mental health division provides the service provider with a written notice of the deficiencies.

(a) If the deficiency has caused or is likely to cause serious injury, harm, impairment or death to a consumer, the deficiencies must be corrected within a timeframe specified by the mental health division;

(b) If the provider fails to complete a corrective action plan or correct deficiencies according to the corrective action plan, the license may be suspended or revoked;

(c) To regain full licensure, a service provider in probationary status must provide a written statement to the mental health division when it has made all required corrective actions and now complies with relevant federal and state law, applicable rules and regulations, and state minimum standards;

(d) The mental health division may conduct an on-site review to confirm that the corrections have been made.

(4) The mental health division may perform an onsite visit to determine the validity of a complaint or notice that a community support service provider is out of compliance with law, applicable rules and regulations, and state minimum standards.

(5) If the service provider does not demonstrate compliance with the requirements of this section, the mental health division may initiate procedures to suspend or revoke a license consistent with state and federal laws, rules and regulations consistent with the provisions of RCW 71.24.035 (7) through (11) and of43.20A.205 .

(6) A regional support network or prepaid health plan may choose to contract with a service provider with a provisional license, full license, or probationary license, but may not contract with a provider with a suspended or revoked license.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0472, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0474 Fees for community support service provider licensure. (1) Fees are due with an initial application or for annual license renewal;

(2) Fees must be paid for a minimum of one year;

(3) If an application is withdrawn prior to issuance or denial, one-half of the fees may be refunded at the request of the applicant;

(4) A change in ownership requires a new license and payment of fees;

(5) Fee payments must be made by check, electronic fund transfer, or money order made payable to the mental health division;

(6) Fees will not be refunded if a license or certificate is denied, revoked, or suspended;

(7) Failure to pay fees when due will result in suspension or denial of the license;

(8) The following fees must be sent with the application for a license or renewal:

Range	Service Hours	Annual Fee
1	0-3,999	$291.00
2	4,000-14,999	422.00
3	15,000-29,999	562.00
4	30,000-49,999	842.00

5	50,000 or more	1,030.00

(9) Annual service hours are computed on the most recent year. For new entities, annual service hours equals the projected service hours for the year of licensure. The provider must report the number of annual service hours based on the mental health division consumer information system data dictionary.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0474, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0476 Licensure based on deemed status. (1) The mental health division may deem compliance with state minimum standards and issue a community support service license based on the provider being currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division. Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency.

(2) The mental health division will only grant licensure based on deemed status to providers with a full license as defined in WAC 388-865-0472.

(3) Specific requirements of state regulation, contract or policy will be waived through a deeming process consistent with the working agreement between the mental health division and the accrediting agency;

(4) Specific requirements of state or federal law, or regulation will not be waived through a deeming process. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0476, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0478 Renewal of a community support service provider license. (1) Each year the community support service provider must renew its license. The community support service provider sends the reapplication for licensure to mental health division along with the required fee.

(2) If the service provider contracts with the regional support network or prepaid health plan it must send a copy of the application to the regional support network or mental health prepaid health plan. The regional support network or mental health prepaid health plan may make written comments to the mental health division about renewing the service provider's license. They must send the service provider a copy.

(3) The mental health division considers the request for renewal, along with any recommendations from the regional support network or mental health prepaid health plan and the results of any onsite reviews completed.

(4) If the provider is in compliance with applicable laws and standards, the mental health division sends the service provider a renewed license, with a copy to the regional support network or mental health prepaid health plan if applicable.

(5) Failure to submit the annual application for renewal license and/or to pay fees when due results in expiration of the license and the provider will be placed on probationary status. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0478, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0480 Procedures to suspend, or revoke a license. (1) The mental health division may suspend, revoke, limit or restrict the license of a community support service provider, or refuse to grant or renew a license for failure to conform to the law, applicable rules and regulations, or state minimum standards.

(2) The mental health division may suspend, revoke, limit or restrict the license of a service provider immediately if there is imminent risk to consumer health and safety.

(3) The mental health division sends a written decision to revoke, suspend, or modify the former licensure status under RCW 43.20A.205, with the reasons for the decision and informing the service provider of its right to an administrative hearing. A copy of the letter will be sent to the area regional support network.

(4) A regional support network or mental health prepaid health plan must not contract with a service provider with a suspended or revoked license.

(5) The mental health division may suspend or revoke a license when a service provider in probationary status fails to correct the health and safety deficiencies as agreed in the corrective action plan with the mental health division.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0480, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0482 Procedures to contest a licensing decision. To contest a decision by the mental health division, the service provider, regional support network, or mental health prepaid health plan must, within twenty-eight calendar days:

(1) File a written application for a hearing with a method that shows proof of receipt to: The Board of Appeals, P.O. Box 2465, Olympia, WA 98504; and

(2) (2) Include in the appeal:

(a) The issue to be reviewed and the date the decision was made;

(b) A specific statement of the issue and law involved;

(c) The grounds for contesting a decision of the mental health division; and

(d) A copy of the mental health division decision that is being contested.

(3) The appeal must be signed by the director of the service provider and include the address of the service provider.

(4) The decision will be made following the requirements of the Administrative Procedure Act, chapter 34.05 RCW and chapter 388-02 WAC.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0482, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0484 Process to certify providers of involuntary services. In order to be certified to provide services to consumers on an involuntary basis, the provider must comply with the following process:

(1) Be licensed as a community support provider consistent with this section or licensed as a community hospital by the department of health;

(2) Complete and submit an application for certification to the regional support network;

(3) The regional support network selects providers for certification and makes a request to the mental health division for certification;

(4) The mental health division conducts an on-site review to examine agency policies and procedures, personnel records, clinical records, financial documents, and any other information that may be necessary to confirm compliance with minimum standards of this section;

(5) The mental health division grants certification based on compliance with the minimum standards of this section and chapter 71.05 RCW;

(6) The certificate may be renewed annually at the request of the regional support network and the provider's continued compliance with the minimum standards of this section;

(7) The procedures to suspend or revoke a certificate are the same as outlined WAC 388-865-0468;

(8) The appeal process to contest a decision of the mental health decision is the same as outlined in WAC 388-865-0482.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0484, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0500 Inpatient evaluation and treatment facilities. The mental health division certifies facilities to provide involuntary inpatient evaluation and treatment services for more than twenty-four hours. Facilities must be certified in order to provide services to consumers who are authorized by the regional support network or mental health prepaid health plan to receive psychiatric inpatient evaluation and treatment services on an involuntary basis.

(1) The following facilities must be licensed by the department of health:

(a) General hospital;

(b) Psychiatric hospital; or

(c) Residential (nonhospital) inpatient facility such as adult residential rehabilitation centers and psychiatric institutions for children and youth.

(2) The following state psychiatric hospitals for adults or children are not licensed by the state, but certified by the Health Care Financing Administration and accredited by the Joint Commission on Accreditation of Healthcare Organizations:

(a) Eastern state hospital;

(b) Western state hospital; and

(c) Child study and treatment center.

(3) No correctional institution or facility, juvenile court detention facility, or jail may be used as an inpatient evaluation and treatment facility within the meaning of this chapter. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0500, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0501 Certification based on deemed status. (1) The mental health division may deem compliance with state minimum standards and issue an inpatient evaluation and treatment certificate based on the provider being currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division. Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency;

(2) The mental health division will only grant certification based on deemed status to providers that have attained full certification as defined in WAC 388-865-0472;

(3) Specific requirements of state regulation, contract or policy will be waived through a deeming process consistent with the working agreement between the mental health division and the accrediting agency;

(4) Specific requirements of state or federal law or regulation will not be waived through a deeming process. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0501, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0502 Single bed certification. At the discretion of the mental health division, an exception may be granted to allow treatment to an adult on a seventy-two hour detention or fourteen-day commitment in a facility that is not certified under WAC 388-865-0500 or for a maximum of thirty days to allow a community facility to provide treatment to an adult on a ninety- or one hundred eighty-day inpatient involuntary commitment order.

(1) The regional support network or its designee must submit a written request for a single bed certification to the mental health division prior to the commencement of the order;

(2) The facility receiving the single bed certification must meet all requirements of this section unless specifically waived by the mental health division;

(3) The request for single bed certification must describe why the consumer meets at least one of the following criteria:

(a) The consumer requires services that are not available at a state psychiatric hospital; or

(b) The consumer is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care.

(4) The mental health division director or the director's designee makes the decision and gives written notification to the requesting regional support network in the form of a single bed certification. The single bed certification must not contradict a specific provision of federal law or state statute;

(5) The mental health division may make site visits at any time to verify that the terms of the single bed certification are being met. Failure to comply with any term of the exception certification may result in corrective action or, if the mental health division determines that the violation places consumers in imminent jeopardy, immediate revocation of the certification;

(6) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding single bed certification decisions by mental health division staff. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0502, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0504 Exception to rule -- Long-term certification. (1) At the discretion of the mental health division, a facility may be granted an exception to WAC 388-865-0229 in order to allow the facility to be certified to provide treatment to adults on ninety-or one hundred eighty-day inpatient involuntary commitment orders.

(2) The exception certification may be requested by the facility, the director of the mental health division or his designee, or the RSN for the facility's geographic area.

(3) The facility receiving the exception certification for ninety- or one hundred eighty-day patients must meet all requirements found in chapter 388-865 WAC for the evaluation and treatment facility short-term inpatient component.

(4) The exception certification must be signed by the director of the mental health division. The exception certification may impose additional requirements, such as types of patients allowed and not allowed at the facility, reporting requirements, requirements that the facility immediately report suspected or alleged incidents of abuse, or any other requirements that the director of the mental health division determines are necessary for the best interests of patients.

(5) The mental health division may make unannounced site visits at any time to verify that the terms of the exception certification are being met. Failure to comply with any term of the exception certification may result in corrective action or, if the mental health division determines that the violation places patients in imminent jeopardy, immediate revocation of the certification.

(6) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding the decision to grant or not to grant exception certification. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0504, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0505 Evaluation and treatment facility certification -- Minimum standards. To gain and maintain certification to provide inpatient evaluation and treatment services under chapter 71.05 and 71.34 RCW, a facility must

meet applicable local, state and federal laws and regulations including department of health licensure requirements and WAC 388-865-500 through 388-865-560:

(1) Designate a physician or other mental health professional as the professional person in charge of that facility. This person must be given the authority and be responsible for:

(a) Making admission and discharge decisions on behalf of that facility;

(b) Supervision of clinical services provided by the facility; and

(c) Explore less restrictive alternatives, in considering the filing of all petitions for involuntary commitments to inpatient treatment including possible community support or residential treatment, to see if the consumer can be as well or better served, preferably within his or her home community.

(2) Have the capability to admit consumers needing inpatient evaluation and treatment services seven days a week, twenty-four hours a day. Psychiatric institutions for children and youth are exempted from this requirement;

(3) Have at least one seclusion room meeting the requirements of WAC 246-320-365 (12)(d)(ii);

(4) Assure access to necessary medical treatment, emergency life-sustaining treatment, and medication.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0505, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0510 Standards for administration. The inpatient evaluation and treatment facility must develop policies to address the following administrative requirements:

(1) Protect clinical records against loss, defacement, tampering, or use by unauthorized persons;

(2) Maintain adequate fiscal accounting records;

(3) Bill and collect payment for services from all private payors and third party payors, including Medicaid and Medicare consumers;

(4) Ensure the protection of consumer and family rights as described in this chapter and chapter 71.05 and 71.34 RCW;

(5) Maintain written protocols to physically and legally detain a consumer who refuses voluntary treatment and meets the legal criteria for involuntary commitment, including the method to contact the county designated mental health professional;

(6) Maintain written procedures for managing assaultive and/or self-injurious consumer behavior;

(7) Maintain written procedures to ensure the safety of children and adults in an inpatient evaluation and treatment facility:

(a) Adults must be separated from children who are not yet thirteen years of age;

(b) Children who have had their thirteenth birthday, but are under the age of eighteen, may be served with adults only if the child's clinical record contains a professional judgment saying that placement in an adult facility will not be harmful to the child or adult.

(8) Develop policies and procedures to inform and provide relevant information on persons who are absent from the facility without leave consistent with RCW 71.05.410 and 71.05.420;

(9) Maintain written procedures to either admit all consumers who have been detained or arrange for transfer to a more appropriate facility only after it is confirmed that the facility will admit the consumer;

(10) Maintain written procedures to ensure the protection of the consumer's property including:

(a) Inventory articles brought to the facility and not kept by the consumer;

(b) Use reasonable precautions to safeguard the property of the consumer.

(11) If the facility treats children, it must maintain written procedures to ensure that:

(a) Whenever a child is conditionally released or discharged before the end of the commitment, the professional person in charge gives the court written notice of the release within three days of the release. If the child is on a one a one hundred and eighty day commitment the children's long-term inpatient placement committee must also be notified.

(b) If the child elopes, the professional person in charge immediately notifies the parents and the appropriate law enforcement agencies.

(12) Maintain written procedures to ensure that upon discharge of a consumer of voluntary services:

(a) The consumer's permission is sought for release of a clinical summary to the community physician, psychiatrist, or therapist of his/her choice, or to the local treatment facility or licensed service provider.

(b) Information sharing complies with RCW 71.05.390.

(c) The consumer is advised of his or her competency and given the following written notice: "No person is presumed incompetent nor does any person lose any civil rights as a consequence of receiving evaluation and treatment services for a mental disorder, whether voluntary or involuntary, as required by RCW 71.05.450."

(13) Maintain written procedures to ensure that the county designated mental health professional who detained a person can not also be one of the two mental health professionals who examines and evaluates a person within twenty-four hours of admission to determine what treatment he or she requires. An exception can be made only by the director or the mental health division and because no other mental health professional is reasonably available to do the necessary examination and evaluation.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0510, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0515 Admission and intake evaluation. The provider must include the following documentation in the intake evaluation:

(1) An initial treatment plan;

(2) A copy of any advance directives, powers of attorney or letters of guardianship provided by the consumer;

(3) That the consumer was advised of his/her rights;

(4) Consideration of a less restrictive treatment alternative for each patient at the time of detention, admission, and discharge;

(5) For consumers who have been involuntarily detained, evaluations to determine the nature of the disorder, the treatment necessary, and whether or not detention is required at least within twenty-four hours of the initial detention of the consumer, including Saturdays, Sundays and holidays. The evaluation must include at least a:

(a) Medical evaluation by a an appropriately licensed medical professional within his/her scope of practice; and

(b) Psychosocial evaluation by a mental health professional.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0515, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0525 Clinical record. The treatment record for each consumer must contain:

(1) A comprehensive plan for treatment developed collaboratively with the consumer;

(2) Copies of advance directives, powers of attorney or letters of guardianship provided by the consumer.

(3) A plan for discharge including a plan for follow-up where appropriate;

(4) Sufficient information to justify the diagnosis;

(5) Documentation that the facility has provided for or arranged for diagnostic and therapeutic services prescribed by the attending professional staff. This may include participation of a multi-disciplinary team or mental health specialists as defined in WAC 388-865-0150, or collaboration with members of the consumer's support system as identified by the consumer;

(6) Documentation of the course of treatment;

(7) Documentation that a mental health professional has contact with each involuntary consumer at least daily for the purpose of:

(a) Observation;

(b) Evaluation; and

(c) Continuity of treatment.

(8) Documentation that a mental health professional and licensed physician are available for consultation and communication with both the consumer and the direct patient care staff twenty-four hours a day, seven days a week;

(9) Documentation of evaluation of each involuntarily committed consumer for release from commitment at least weekly for fourteen-day commitments.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0525, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0530 Competency requirements for staff. In order to gain and maintain certification as an inpatient evaluation and treatment facility, the provider must document that staff are qualified for the position they hold and have the education, experience, or skills to perform the job requirements, including:

(1) All staff have a current Washington state department of health license or certificate or registration as may be required for his/her position;

(2) Washington state patrol background checks are conducted for employees in contact with consumers consistent with RCW 43.43.830;

(3) Clinical supervisors meet the qualifications of mental health professionals or specialists as defined in WAC 388-865-0150;

(4) Staff receive an annual performance evaluation; and

(5) An individualized annual training plan must be implemented for each direct service staff person and supervisor in the skills he or she needs for his/her job description and the population they serve. Such training must include at least:

(a) Least restrictive alternative options available in the community and how to access them;
(b) Methods of patient care;
(c) Management of assaultive and self-destructive behavior; and
(d) The requirements of chapter 71.05 and 71.34 RCW, this chapter, and protocols developed by the mental health division.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0530, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0535 The process for gaining certification and renewal of certification. These processes are the same as described in WAC 388-865-0484.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0535, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0540 Fees for evaluation and treatment facility certification. Inpatient facilities certified to provide inpatient evaluation and treatment services are assessed an annual fee of thirty-two dollars per bed. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0540, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0545 Use of seclusion and restraint procedures -- Adults. Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:
(1) Staff must notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion;
(2) The consumer must be informed of the reasons for use of seclusion or restraint and the specific behaviors which must be exhibited in order to gain release from these procedures;
(3) The clinical record must document staff observation of the consumer at least every fifteen minutes and observation recorded in the consumer's clinical record;
(4) If the use of restraint or seclusion exceeds twenty-four hours, a licensed physician must assess the consumer and write a new order if the intervention will be continued. This procedure is repeated again for each twenty-four hour period that restraint or seclusion is used;
(5) All assessments and justification for the use of seclusion or restraint must be documented in the consumer's medical record. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0545, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0546 Use of seclusion and restraint procedures -- Children. Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:
(1) In the event of an emergency use of restraints or seclusion, a licensed physician must be notified within one hour and must authorize the restraints or seclusion;
(2) No consumer may be restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional. Such consumer must be directly observed every fifteen minutes and the observation recorded in the consumer's clinical record;
(3) If the restraint or seclusion exceeds twenty-four hours, the consumer must be examined by a licensed physician. The facts determined by his or her examination and any resultant decision to continue restraint or seclusion over twenty-four hours must be recorded in the consumer's clinical record over the signature of the authorizing physician. This procedure must be repeated for each subsequent twenty-four hour period of restraint or seclusion.
[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0546, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0550 Rights of all consumers who receive community inpatient services. The rights assured by RCW 71.05.370 and the following rights must be prominently posted within the department or ward of the community or inpatient evaluation and treatment facility. You have the right to:

(1) Adequate care and individualized treatment.

(2) To have all information and records compiled, obtained, or maintained in the course of receiving services kept confidential, under the provisions of RCW 71.05.390, 71.05.420, and 71.34.160. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0550, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0555 Rights of consumers receiving involuntary inpatient services. Consumers who are receiving inpatient services involuntarily have the rights provided in RCW 71.05.370 plus the following rights. The provider must ensure consumers are informed of his or her rights and that all consumer rights are protected, including:

(1) At admission, each consumer must be informed in writing or orally of his or her rights to have a responsible member of the immediate family if possible, guardian or conservator, if any, and such other person as designated by the consumer given written notice of the consumer's inpatient status, and his or her rights as an involuntary consumer;

(2) A medical and psychosocial evaluation within twenty-four hours of admission to determine whether continued detention in the facility is necessary;

(3) A judicial hearing before a superior court if the consumer is not released within seventy-two hours (excluding Saturdays, Sundays, and holidays), to decide if continued detention within the facility is necessary. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0555, filed 5/31/01, effective 7/1/01.]

(4)

WAC 388-865-0557 Rights related to antipsychotic medication. All consumers have a right to make an informed decision regarding the use of antipsychotic medication consistent with the provisions of RCW 71.05.370(7) and 71.05.215. The provider must develop and maintain a written protocol for the involuntary administration of antipsychotic medications, including the following requirements:

(1) At the time of admission inform the consumer of his or her right to:

(a) Make an informed decision regarding the use of antipsychotic medication;

(b) Refuse all treatment except lifesaving treatment beginning twenty-four hours prior to any hearing;

(c) Refuse antipsychotic medication beginning twenty-four hours before any court proceeding wherein the consumer has the right to attend and is related to his or her continued commitment;

(d) The consumer must be asked if he or she wishes to decline treatment during the twenty-four hour period, and the answer must be in writing and signed when possible. Compliance with this procedure must be documented in the consumer's clinical record.

(2) The clinical record must document:

(a) The physician's attempt to obtain informed consent;

(b) The reasons why any antipsychotic medication is administered over the consumer's objection or lack of consent.

(3) The physician may administer antipsychotic medications over a consumer's objections or lack of consent only when:

(a) An emergency exists, provided there is a review of this decision by a second physician within twenty-four hours. An emergency exists if:

(i) The consumer presents an imminent likelihood of serious harm to self or others;

(ii) Medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and

(iii) In the opinion of the physician, the consumer's condition constitutes an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second physician.

(b) There is an additional concurring opinion by a second physician for treatment up to thirty days;

(c) For continued treatment beyond thirty days through the hearing on any one hundred eighty-day petition filed under RCW 71.05.370(7), provided the facility medical director or director's medical designee reviews the decision to medicate a consumer. Thereafter, antipsychotic medication may be administered involuntarily only upon order of the court. The review must occur at least every sixty days.

(4) The examining physician must sign all one hundred eighty-day petitions for antipsychotic medications files under the authority of RCW 71.05.370(7);

(5) Consumers committed for one hundred eighty days who refuse or lack the capacity to consent to antipsychotic medications have the right to a court hearing under RCW 71.05.370(7) prior to the involuntary administration of antipsychotic medications;

(6) In an emergency, antipsychotic medications may be administered prior to the court hearing provided that an examining physician files a petition for an antipsychotic medication order the next judicial day;

(7) All involuntary medication orders must be consistent with the provisions of RCW 71.05.370 (7)(a) and (b), whether ordered by a physician or the court;

(8) This section does not preclude use of physical restraints and/or seclusion in compliance with WAC 388-865-0545 and 388-865-0546. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0557, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0560 Rights of consumers who receive emergency and inpatient services voluntarily. (1) At admission, each consumer must be informed in writing or orally of his or her right to immediate release, and other rights as defined in this section and in RCW 71.05.050 for adults and chapter 71.34 RCW for children.

(2) The following rights of voluntary consumers must be prominently displayed within the department or ward where the consumer is housed. You have the right to:

(a) Release, unless involuntary commitment proceedings are initiated.

(b) A review of condition and status at least each one hundred and eighty days as required under RCW 71.05.050, 71.05.380, and 72.23.070.

(3) All voluntary consumers have the right to:

(a) Adequate care and individualized treatment;

(b) Make an informed decision about the use of antipsychotic medication. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0560, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0565 Petition for the right to possess a firearm. A person is entitled to the immediate restoration of the right to firearm possession when he or she no longer require treatment or medication for a condition related to the involuntary commitment. This is described in RCW 9.41.040 (6)(c).

(1) The person who wants his or her right to possess a firearm restored may petition the court that ordered involuntary treatment or the superior court of the county in which he or she lives for a restoration of the right to possess firearms. At a minimum, the petition must include:

(a) The fact, date, and place of involuntary treatment;

(b) The fact, date, and release from involuntary treatment;

(c) A certified copy of the most recent order of commitment with the findings and conclusions of law.

(2) The person must show the court that he/she no longer require treatment or medication for the condition related to the commitment.

(3) If the court requests relevant information about the commitment or release to make a decision, the mental health professionals who participated in the evaluation and treatment must give the court that information. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0565, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0600 Purpose. In order to enhance and facilitate the department of corrections' ability to carry out its responsibility of planning and ensuring community protection, mental health records and information, as defined in this section, that are otherwise confidential shall be released by any mental health service provider to the department of corrections personnel for whom the information is necessary to carry out the responsibilities of their office as authorized in RCW 71.05.445 and 71.34.225. Department of corrections personnel must use records only for the stated purpose and must assure that records remain confidential and subject to the limitations on disclosure outlined in chapter 71.05 RCW, except as provided in RCW 72.09.585.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0600, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0610 Definitions. Relevant records and reports includes written documents obtained from other agencies or sources, often referred to as third-party documents, as well as documents produced by the agency receiving the request. Relevant records and reports do not include the documents restricted by either federal law or federal regulation related to treatment for alcoholism or drug dependency or the Health Insurance Portability and Accountability Act or state law related to sexually transmitted diseases, as outlined in RCW 71.05.445 and 71.34.225.

(1)"Relevant records and reports" means:

(a) Records and reports of inpatient treatment:

(i) Inpatient psychosocial assessment - Any initial, interval, or interim assessment usually completed by a person with a master's degree in social work (or equivalent) or equivalent document as established by the holders of the

records and reports;

(ii) Inpatient intake assessment - The first assessment completed for an admission, usually completed by a psychiatrist or other physician or equivalent document as established by the holders of the records and reports;

(iii) Inpatient psychiatric assessment - Any initial, interim, or interval assessment usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(iv) Inpatient discharge/release summary - Summary of a hospital stay usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(v) Inpatient treatment plan - A document designed to guide multi-disciplinary inpatient treatment or equivalent document as established by the holders of the records and reports;

(vi) Inpatient discharge and aftercare plan database - A document designed to establish a plan of treatment and support following discharge from the inpatient setting or equivalent document as established by the holders of the records and reports.

(b) Records and reports of outpatient treatment:

(i) Outpatient intake evaluation - Any initial or intake evaluation or summary done by any mental health practitioner or case manager the purpose of which is to provide an initial clinical assessment in order to guide outpatient service delivery or equivalent document as established by the holders of the records and reports;

(ii) Outpatient periodic review - Any periodic update, summary, or review of treatment done by any mental health practitioner or case manager. This includes, but is not limited to: documents indicating diagnostic change or update; annual or periodic psychiatric assessment, evaluation, update, summary, or review; annual or periodic treatment summary; concurrent review; individual service plan as required by WAC 388-865-0425 through388-865-0430 , or equivalent document as established by the holders of the records and reports;

(iii) Outpatient crisis plan - A document designed to guide intervention during a mental health crisis or decompensation or equivalent document as established by the holders of the records and reports;

(iv) Outpatient discharge or release summary - Summary of outpatient treatment completed by a mental health professional or case manager at the time of termination of outpatient services or equivalent document as established by the holders of the records and reports;

(v) Outpatient treatment plan - A document designed to guide multi-disciplinary outpatient treatment and support or equivalent document as established by the holders of the records and reports.

(c) Records and reports regarding providers and medications:

(i) Current medications and adverse reactions - A list of all known current medications prescribed by the licensed practitioner to the individual and a list of any known adverse reactions or allergies to medications or to environmental agents;

(ii) Name, address and telephone number of the case manager or primary clinician.

(d) Records and reports of other relevant treatment and evaluation:

(i) Psychological evaluation - A formal report, assessment, or evaluation based on psychological tests conducted by a psychologist;

(ii) Neuropsychological evaluation - A formal neuropsychological report, assessment, or evaluation based on neuropsychological tests conducted by a psychologist;

(iii) Educational assessment - A formal report, assessment, or evaluation of educational needs or equivalent document as established by the holders of the records and reports;

(iv) Functional assessment - A formal report, assessment, or evaluation of degree of functional independence. This may include but is not limited to: occupational therapy evaluations, rehabilitative services database activities assessment, residential level of care screening, problem severity scale, instruments used for functional assessment or equivalent document as established by the holders of the records and reports;

(v) Forensic evaluation - An evaluation or report conducted pursuant to chapter 10.77 RCW;

(vi) Offender/violence alert - A any documents pertaining to statutory obligations regarding dangerous or criminal behavior or to dangerous or criminal propensities. This includes, but is not limited to, formal documents specifically designed to track the need to provide or past provision of: duty to warn, duty to report child/elder abuse, victim/witness notification, violent offender notification, and sexual/kidnaping offender notification per RCW 4.24.550, 10.77.205, 13.40.215, 13.40.217, 26.44.330, 71.05.120, 71.05.330, 71.05.340, 71.05.425, 71.09.140, and 74.34.035;

(vii) Risk assessment - Any tests or formal evaluations administered or conducted as part of a formal violence or criminal risk assessment process that is not specifically addressed in any psychological evaluation or neuropsychological evaluation.

(e) Records and reports of legal status - Legal documents are documents filed with the court or produced by the court indicating current legal status or
legal obligations including, but not limited to:

(i) Legal documents pertaining to chapter 71.05 RCW;

(ii) Legal documents pertaining to chapter 71.34;

(iii) Legal documents containing court findings pertaining to chapter 10.77 RCW;

(iv) Legal documents regarding guardianship of the person;

(v) Legal documents regarding durable power of attorney;

(vi) Legal or official documents regarding a protective payee;

(vii) Mental health advance directive.

(2) "Relevant information" means descriptions of a consumer's participation in, and response to, mental health treatment and services not available in a relevant record or report, including all statutorily mandated reporting or duty to warn notifications as identified in WAC 388-865-610 (1)(d)(vi), Offender/Violence alert, and all requests for evaluations for involuntary civil commitments under chapter 71.05 RCW. The information may be provided in verbal or written form at the discretion of the mental health service provider. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0610, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0620 Scope. Many records and reports are updated on a regular or as needed basis. The scope of the records and reports to be released to the department of corrections are dependent upon the reason for the request.

(1) For the purpose of a pre-sentence investigation release only the most recently completed or received records of those completed or received within the twenty-four-month period prior to the date of the request; or

(2) For all other purposes release all versions of records and reports that were completed or received within the ten year period prior to the date of the request that are still available. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0620, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0630 Time frame. The mental health service provider shall provide the requested relevant records, reports and information to the authorized department of corrections person in a timely manner, according to the purpose of the request:

(1) Pre-sentence investigation - within seven calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the seven-day-period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(2) All other purposes - within thirty calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the thirty-day period and provide the requested relevant records, reports or information within a mutually agreed to time period. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0630, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0640 Written requests. The written request for relevant records, reports and information shall include:

(1) Verification that the person for whom records, reports and information are being requested is under the authority of the department of corrections, per chapter 9.94A RCW, and the expiration date of that authority.

(2) Sufficient information to identify the person for whom records, reports and information are being requested including name and other identifying data.

(3) Specification as to which records and reports are being requested and the purpose for the request.

(4) Specification as to what relevant information is requested and the purpose for the request.

(5) Identification of the department of corrections person to whom the records, reports and information shall be sent, including the person's name, title and address.

(6) Name, title and signature of the requestor and date of the request.[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0640, filed 5/31/01, effective 7/1/01.]